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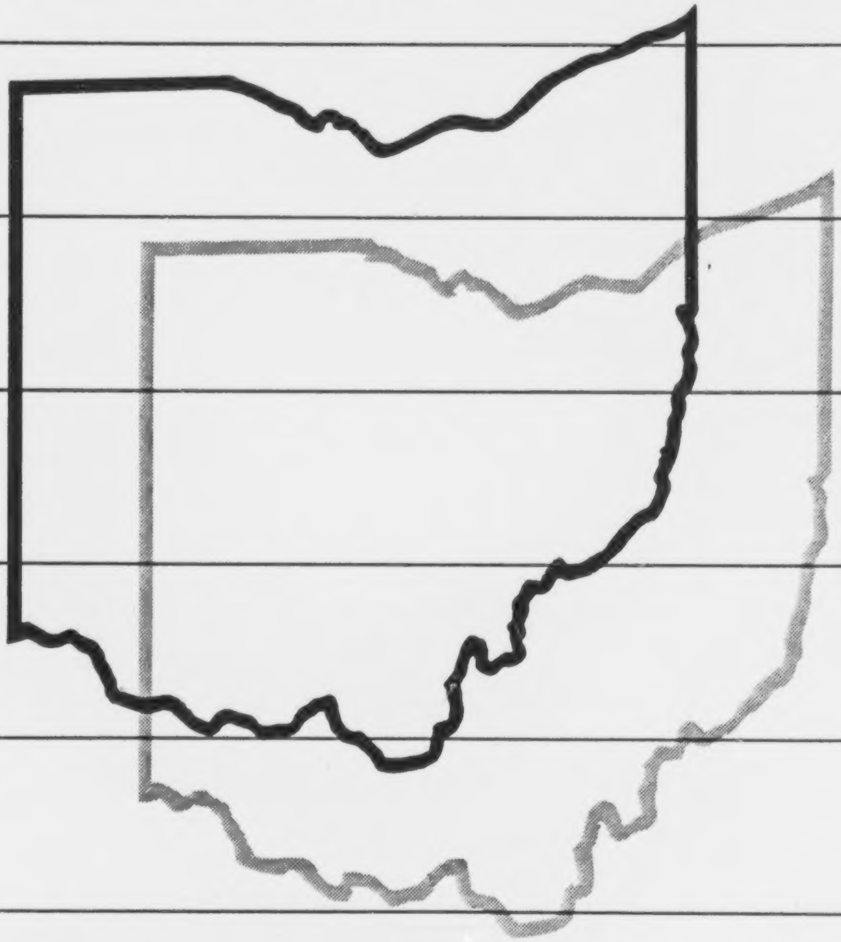
Homelessness in Ohio:

a study of people in need



Statewide Report

Ohio Department of Mental Health
Office of Program Evaluation and Research

Research funded by the
National Institute of Mental Health

Homelessness in Ohio: A Study of People in Need

Statewide Report

by

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Ohio Department of Mental Health
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We respectfully dedicate this report to all of the homeless people in Ohio, especially those who were gracious enough to share their lives and their problems with us in an interview. We hope the study, and our sharing results with policy-makers around the state, will be a catalyst for the development of the kinds of programs and policies that will provide long-term solutions.

February 1985 Dee Roth

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INTRODUCTION

Problem Statement

Homelessness in America has emerged, especially within the last decade, as a social problem of considerable depth and magnitude. Popular notions about homeless people as skid row bums ravaged by alcoholism or as somewhat romanticized open-road travelers unencumbered by the many pressures of daily living have given way to the view that many of the homeless in this country are people who have been displaced by social policies and processes far beyond their control. It has been suggested that what America is faced with in this growing group of homeless people is a "new mendicancy" (Baxter and Hopper, 1982).

Estimates of the size of America's homeless population have been difficult to make. Figures range from 192,000 people (U.S. Department of Housing and Urban Development, 1984) to 2.2 million people (Hombs & Snyder, 1982), or one percent of America's total population. The primary reason for such variability in estimates relates to the substantial problems encountered when trying to find and study the homeless population. Certain characteristics of the group such as transience, seasonal variations in location and composition, reluctance to use charity or social services, and a lack of willingness and capacity to be interviewed establish real barriers to an accurate count or an in-depth examination of the homeless in this country.

It has been suggested that some of the reasons for the swelling ranks of America's homeless population can be traced directly to recent social and economic policies and processes. Over the past decade, economic difficulties have literally disenfranchised many of the most vulnerable groups in this society (Hombs and Snyder, 1982). Inflation, unemployment and choices about national priorities for tax dollars have dramatically affected the lives of the elderly, the poor, minority groups and the disabled. Affordable housing is no longer a possibility for many people. Inner city groups have been displaced by urban development projects and have found that the only place to go is into abandoned or "worthless" parts of the city. For many of these people, a homeless existence is their only real choice.

Deinstitutionalization policies and practices have also been proposed as being linked to increases in the homeless population in America. Leepson (1982, p. 796) notes,

> "The number of patients in U.S. mental hospitals dropped to 150,000 in 1978 — the complete statistics are available — from a peak of about 650,000 in the mid-1950s. Many of the deinstitutionalized patients have been placed in nursing homes or community mental health centers. But there are only about 800 local mental health facilities across the country—not nearly enough to accommodate the need. Many former mental patients are therefore either under-served or unserved by community outpatient facilities. Often they wind up on the streets."

Not all researchers agree that deinstitutionalization has had such a dramatic impact on the homeless population. In a recent New York State Office of Mental Health study (1982), researchers found that of 107 randomly-selected users of men's shelters, one-third had psychiatric hospitalizations and one-fifth had been in state hospitals. They further qualified their findings, however, with this statement:

> "There is little justification for the assertion that the growth in the homeless population seen today is due to large numbers of releases from

> state hospitals. Of the 22 percent who were ever in a state hospital, close to half were released more than 5 years ago. Furthermore, only 15% were thought to be homeless because of mental problems." (p. 13)

Citing a close link between deinstitutionalization and homelessness among the chronically mentally ill population, the American Psychiatric Association (Lamb, 1984) asserts that it is not the result of deinstitutionalization per se, but the way deinstitutionalization has been carried out, i.e., lack of planning for structured living arrangements and for adequate treatment and rehabilitative services in the community.

While recent attention to homelessness has increased, it is still the case that what is "known" about the condition and circumstances of homeless people is minimal. There has been no real sense of accumulation of knowledge about homelessness in the literature. In fact, the literature on homelessness, both empirical and popular, is a morass of speculative, value-laden and overblown generalizations about both the causes of the condition and who should be responsible for meeting the needs of homeless people. In the face of this confusion and gaps in knowledge, it has been very difficult for policy makers and program planners to address the problem in a meaningful and effective way.

This study was intended to address some of those knowledge gaps by examining characteristics, concerns and mental health needs of homeless people. The research addressed several areas that have both state and national implications. First, there was an effort to examine many of the major issues surrounding homelessness, for example the demographic characteristics of the population, their mobility patterns, the reasons for their homelessness, their use of social and mental health services and contact with family and friends. Second, the research looked at the interaction between homelessness and mental health problems and policies from a number of standpoints. The level of mental health problems was assessed in the entire interview population, in order to give planners and service providers a data base from which to estimate needs. Special attention was focused on ascertaining the number of homeless people who have had prior mental health service contacts and the nature of those contacts, and the number of those individuals who may still need services. In addition, the study addressed the issue of whether homeless people who have not had prior mental health agency contact have unmet mental health needs. Studies in New York and California have indicated that a number of homeless people who have not had prior contact with a service provider do have mental health problems, but there had been no comprehensive research on this issue that would define the scope of the problem for policy makers or would point to appropriate solutions. Finally, this study attempted to reduce many of the methodological limitations of previous research and achieve a more comprehensive picture of homeless people through the inclusion of interviewees from major urban areas as well as rural areas and small cities. In addition, data were collected from individuals in a wide range of homeless conditions, not just in shelters.

Ohio was an excellent setting for this study because the state is, according to 1980 Census data, very similar demographically to the rest of the country. Ohio's total 1980 population of 10,797,419, the sixth largest state in the nation, was distributed across 88 counties ranging in size from Cuyahoga County with 1,498,295 to Noble County with 11,584. The state has been characterized as being close to the national average on the mix of rural/urban population and in the distribution of race, age, education and income. Further, Ohio is a state undergoing significant changes in both its economic base and population distribution and composition. The state is experiencing first-hand many of the forces and policies that have been purported to be related to the condition of homelessness. The fact that Ohio has a large population and is similar to the rest of the country considerably strengthens the generalizability of study results.

Research Objectives

The research project, "Prevalence of Mental Health Problems Among Homeless People", was conducted to more thoroughly understand the nature of the population, and the relationship between mental health policies and procedures and homelessness. While the argument that deinstitutionalization policies and restrictive admission procedures have had unintended negative effects on some patients appears to be well supported, the extent to which people have been displaced by these policies and procedures and end up homeless is still a matter of some debate. More is needed to be known about the existing mental health needs of homeless people, because, as noted above, gaps in knowledge about homelessness and mental health preclude any meaningful efforts to alter or devise policies and services responsive to the needs of those who are homeless.

This study was, therefore, designed to address key issues about a wide range of homeless people in Ohio. The primary objectives of the study are:

1) To describe characteristics of homeless people, particularly those who might be mentally ill. The general categories of information collected about the respondent group included:

   - homeless condition
   - history of psychiatric hospitalization
   - employment history
   - social support
   - use of social services
   - income
   - medical problems
   - demographic information
   - general well-being
   - current mental health status

2) To examine, on the basis of the above information and through data collected from Ohio state psychiatric facilities and selected community mental health centers, if and how mental health policies and efforts to deinstitutionalize mental hospitals may have contributed to the homeless population in Ohio.

In addition to these primary objectives, the study was designed to permit an examination of the relationship between the various characteristics of homeless people. The following is a list of the relationships to be examined:

1) Is there correspondence between the assessments and perceptions of key informants relative to the condition and problems of homeless people and the data provided by homeless people themselves?

2) Are there differences in characteristics or functioning between homeless people located in rural areas and those located in urban areas?

3) Are there differences in characteristics or functioning between homeless people located in different regions of Ohio?

4) Are there differences in characteristics or functioning based on type of homeless condition?

5) Are there differences in characteristics or functioning based on degree of transience?

6) Is there a proportion of homeless people not having had prior mental health system contact who have current mental health service needs?

7) Is there a characteristic or set of characteristics of homeless people that tend to systematically relate to general well-being or mental health status?

Organizational Structure

The study was begun in November 1983, by the Ohio Department of Mental Health, in conjunction with a statewide team of university researchers from different regions in Ohio. Overall coordination and direction of the project, as well as the overall data analysis, report writing and interfacing with the state mental health delivery system, was done by the Ohio Department of Mental Health Office of Program Evaluation and Research. The research team members assisted in planning and developing various components of the work, including sampling procedures, instrumentation construction and pilot testing, interviewing of key informants, and data collection and analysis.

For data collection purposes, the state was divided into five regions. The university team members became Regional Coordinators of their specific regions and were charged with overall supervision of data collection in those respective regions. Field Coordinators were hired in each of the five regions to oversee the hiring of field interviewers, supervise the field interviewers and assure the timely collection of data from the field.

METHODOLOGY

General Design

Information necessary to address the above research objectives was obtained through four data collection efforts.

Key Informant Survey. The key informant survey was designed with two purposes in mind. First, it was intended to collect data about where homeless people could be found in a particular geographical area, and how best to approach them for interviews. This information was important to the study from a methodological standpoint since it assisted in both the development of a sampling plan and the training of interviewers. Second, key informants were asked about their perceptions and opinions of the condition and problems of homeless people in their geographical area, the causes of homelessness, services available and the like.

Homeless Person Survey. This survey was designed to collect information from people who were experiencing homelessness firsthand. The plan was to interview 1000 homeless people selected through as random a process as possible given situational constraints. Twenty randomly selected counties were identifed as interview sites.

Community Mental Health Agency Survey. This survey was designed to identify the individuals discharged from state psychiatric hospitals during Fiscal Years 1982-1983 who have been homeless following their release from the hospital.

State Psychiatric Hospital Survey. This survey was developed to identify the individuals who were homeless at the time of admission to adult state psychiatric hospitals during a six-month period in 1984.

Definition of Key Terms

What follows is a discussion about how two key terms, "homelessness" and "mental health status", were defined and operationalized in the study.

Homelessness. Using the notion that a variety of conditions can constitute "homelessness", and focusing on the physical location component of the definition, homelessness in this study was conceptualized as existing on a continuum. A series of anchor points along this continuum was identified and later critiqued by members of the research team after talking with key informants and pilot testing draft versions of the instrument. The resulting definition used in this study is as follows:

A person is homeless if he/she sleeps/lives in:

1) Limited or no shelter for any length of time. (Examples include: under bridges, inside door stoops, in cars, in abandoned buildings, in a bus station or all-night cafe, or in any public facility.)

2) Shelters or missions run by religious organizations or public agencies for any length of time. These facilities are specifically for homeless people, are run on a drop-in basis, and charge no fee or a minimal fee. (Examples include: Salvation Army, Volunteers of America, Open Shelter of Columbus.)

3) Cheap hotels or motels when actual length of stay, or the intent to stay, is 45 days or less.

4) Other unique situations that do not fall into categories 1 - 3 and the actual length of stay, or the intent to stay, is 45 days or less. (Examples include: staying with family and friends, tent cities and having spent a night in jail.)

Based on the definition, it was decided that the following kinds of people were not to be considered homeless: battered women living in shelters for battered women; people who lose their jobs because of cyclical reasons/traditional plant closings, etc., and move into relatives'/friends' homes for the time that they are unemployed, understanding that their jobs may be regained at some future date; people living in shacks on property that they own; and travelers who, because of a lack of money, are forced to accept shelter for the night, but who have come from a permanent home and are going to a permanent home. Further, it was necessary to put a cap on length of stay, or intent to stay, in categories three and four to discriminate between people who move in and out of those settings and those who tended to be there more permanently.

This operational definition was responsive to the needs of the research in three ways. First, it established the basic criteria to be met by respondents in order to be included in the study. The first two questions of the Homeless Person Survey Instrument, which enabled interviewers to screen potential respondents for inclusion in the study, are based on the above definition. Second, by expanding the definition of homelessness to include a range of living conditions, it was also possible to increase the variability of responses to other questionnaire items. Finally, the definition was a meaningful way to define subgroups of homeless people about which differential problems and/or needs were discovered. In fact, the sampling plan for the homeless person survey discussed in a later section of this report stratified on the dimensions identified in the operational definition to assure that differences between the groups would be detected if they existed.

Mental Health Status. Because of the key nature of this concept to study objectives, considerable thought was given to its definition and operationalization. Prior studies of the prevalence of psychiatric disorders in general populations, however, were not particularly helpful in the definitional effort.

These difficulties notwithstanding, decisions had to be made about how to define and measure mental health status. A fairly traditional approach was used in the study from the standpoint that mental status was viewed principally within a "symptom" framework. That is, mental illness was defined as the presence of symptoms along dimensions the literature identified as associated with psychiatric problems. Conversely, mental health was viewed as being symptom free. The Psychiatric Status Schedule (to be discussed in more detail in the Instrumentation Section) was chosen to operationalize our definition.

Sampling Plan and Data Collection Activities

The study contained four data collection activities which required attention to a sampling plan: the Key Informant Survey, the Homeless Person Survey, the Community Mental Health Agency Survey and the State Psychiatric Hospital Survey.

Key Informant Survey

Within each of the five data collection regions a sample of key informants was interviewed by telephone or, if necessary, in person. The first step in choosing a sample of people to be interviewed was to identify a pool of informed individuals who could help the Regional Coordinators locate potential key informants or serve as informants themselves. To assure a wide variety of respondents, Regional Coordinators made contact with someone in a position of authority in each of at least ten service/agency categories (if they existed) within each of the sample counties. In the final selection of key informants, an attempt was made to have the group be representative of as wide a variety of service/agency categories as possible. Additional key informants were interviewed throughout the project, especially in rural areas, as necessary to identify more sources of homeless people to interview. In all, a total of 164 key informants in nine service/agency categories were interviewed.

Homeless Person Survey

The purpose of the survey of homeless persons was to develop descriptive data about the urban and non-urban population of homeless people in Ohio. While it was impossible to utilize a random sample plan which was truly representative in the strictist research terms, the study attempted to construct a sample which could claim good representativeness of the state, as well as solid representation of both non-urban and urban homelessness. In designing the sampling plan, care was taken to assure that individuals throughout the state would be included, and that the sample would contain individuals from both urban and non-urban areas. The first step involved dividing Ohio's 88 counties into five geographic regions. While the five state regions are roughly equivalent in geographic area, there is considerable variation in the population of these regions. Interview quotas were initially established for each region, giving consideration to both the relative proportion of the population and possible regional variability.

Sampling Counties. Within each region, four counties were selected for inclusion in the study. The county containing the major urban center was automatically included.

The other three counties in each region were selected according to the Ohio Department of Health's schema, based on census data, for classifying counties into three categories: urban, mixed, and rural. One county of the mixed type was selected, by using a random numbers table, from all counties of this type in the region. Two counties in the rural category were similarly selected from all rural counties in each region.

Twenty Ohio counties were included in the initial sample, four from each of the five designated regions. Four of those counties were clearly urbanized. (The Southeast Region does not have a county with a large enough city to qualify as being urban according to the Ohio Department of Health schema.) Six counties were mixed (two in the Southeast region), and ten were rural.

The number of interviews to be obtained within each region was distributed among the four counties proportionate to their population. A revision was made, however, to elevate the sampling in rural areas such that no fewer than 25 interviews would be obtained from any given county.

Stratification of the Homeless Sample. For sampling purposes, homeless people were stratified according to their level of homeless condition. (These levels are described in detail in an earlier section of this report entitled "Definition of Terms".) It is acknowledged that these levels are not necessarily static; individuals change their homeless condition due to seasonal and other variations. For the purposes of this study, and to facilitate sampling procedures, the homeless individual was categorized as to where he/she slept last night. If the person had become homeless exactly on the day of the interview, his/her homeless condition was categorized as to where he/she would sleep the coming night.

The original sampling plan was the same for all counties, i.e., using the four-level definition of homeless condition, divide the total county sample quota by four, and attempt to get one-fourth of the total county sample in each level. Interview sites were to be varied, and random procedures were to be used as much as possible. Intermediaries were to be avoided. Changes in the sampling plan had to be made as the realities of such a large-scale data collection effort became apparent.

Mixed and Rural Counties. Work with key informants indicated that there were not large enough numbers of homeless persons in the mixed and rural counties to follow the sampling plan. The research team decided, therefore, to try to interview the total population of homeless persons identified in the mixed and rural counties, regardless of their level of homelessness. This was necessary in order to reach the minimum quota of 25 interviews per county. Because of the difficulty in finding homeless people in the mixed and rural counties (especially for interviewers not indigenous to the county), key informants and other community people were recruited as contacts to notify project staff as homeless people were identified in their counties.

Urban Counties. Interviewing approximately equal numbers of homeless people in the four levels turned out to be relatively easy. Sites were identified where homeless people could be found in each level of the definition of homeless condition. From these identified sites, some were randomly chosen for interviewing homeless people. However, in some cities, there were not enough different sites at which homeless people could be found for interviews, and thus, some sites had to be "re-cycled". No more than five homeless people were interviewed at a time at one particular site.

In the cities, interviewing began in the shelters. This was thought necessary because it was still wintertime, and some shelters close in late spring. We wanted to be sure to reach our quota of shelter occupants. Also, it was felt that the shelter population was the most easily accessible and would afford the interviewers a chance for success, i.e., getting interviews early on in the project, thus heightening their interest in the whole interview process. Subjects were chosen in as random a fashion as possible.

Sampling Problems and Changes Made. In the later stages of the data collection effort, it became evident that sampling quotas would not be met in some of the mixed and rural counties. Homeless people in sufficient numbers to satisfy the established quotas just were not there, or we could not locate them. In order to maintain the regional quota of interviews, therefore, unobtainable interviews in the mixed and rural counties were reallocated to the urban county where we knew that additional interviews could be completed. However, in the Southeast Region, there was no real urban county to which we could reallocate the unmet quota of rural/mixed interviews. It was thus decided to select another urban area, Mahoning County, as a place to reallocate the remaining Southeast Region interviews. These interviews are considered part of the urban sample, however, for data analysis purposes, and Mahoning County has its own report in the series of regional reports.

Methodological Concerns. In all research projects there are methodological issues which require the use of judgment. In some instances there is no clearly right or wrong way to proceed, merely a choice with various implications and limitations. In other cases there are ways to accomplish a task which are standard scientific practice. However, if those methods are not feasible, a best alternative must be used. This was the situation the research team faced in devising a sampling plan for the highly mobile homeless population. Therefore, the following cautions are offered regarding the generalizability of the sample.

The most important issue of concern is the representativeness of the sample, since randomization (the best methodology) was not entirely feasible. Textbooks in research suggest that "the term representativeness has no precise meaning" (Babbie, 1983). To some, representative means the sample has the aggregate characteristics which closely approximate those of the proposed population. Others will only use the term representative when the sample has been drawn using probability techniques. However, it is important to remember that even with probability methods, a perfectly representative sample is seldom obtained. Although we were limited in our ability to use a totally random process, random procedures were used whenever possible, as in the selection of the sampling sites, and the selection of individuals within the sites where more than a few homeless people were gathered.

Purposive processes were used to generate the lists of areas where homeless people might be found. In settings like diners, parks, public buildings, etc., homeless people were selected by encounter and willingness to be engaged. In these situations, random methods were not feasible. To further protect the study from bias, interviewers kept log sheets of all encounters, documenting the characteristics of those who refused to be interviewed or were incapable of being interviewed. This information was subsequently used to assess whether those refusing to be interviewed were significantly different from those in the sample.

The use of the careful purposive methods, the information of key informants, the contact log records, and randomization when possible, provide support for the claim of representativeness of the samples in each urban county. In the non-urban counties, the project staff tried to interview every identified homeless person and thus feel this sample comes close to being the population of homeless people in the mixed and rural counties sampled.

Community Mental Health Agency Survey

The sample included all individuals discharged from state psychiatric hospitals during Fiscal Year 1982 and Fiscal Year 1983 who were residents of the twenty selected counties. It was estimated that the sample represented approximately 48 percent of the total pool of the unduplicated count of persons discharged from state psychiatric hospitals in the State of Ohio during that period. Community mental health agencies in the twenty sample counties were asked to identify from computer-generated lists of discharged clients those who were on their active files, as well as those who were known to have been homeless at any time following their discharge from the hospital.

In the four major urban counties where the county area is covered by a large number of mental health agencies, the Community Mental Health Boards assisted in the identification of the clients discharged by community service area, utilizing their computerized information systems.

State Psychiatric Hospital Survey

All patients admitted during the interval from March 15 to September 14, 1984 were evaluated by hospital social workers with regard to their housing status within ten days after admission. Only direct admissions to state psychiatric hospitals were evaluated, including those of persons referred by the courts and law enforcement agencies (in which case the housing status might have been ascertained from the documents provided by the referral source).

Information concerning the identity of the homeless patients admitted and their homeless condition was collected and forwarded by each hospital on a monthly basis using the data collection instrument developed for this study.

Instrumentation Design

Key Informant Survey Instrument

Items chosen for inclusion in this questionnaire came from a variety of sources including already developed survey instruments used in other research studies on homelessness. The questionnaire contained three sections. Section one attempted to measure the informants' attitudes and perceptions about the homeless population, i.e., demographics, factors associated with homelessness, problems experienced by homeless persons, community services needed by this population and the degree of effectiveness of those services provided to homeless persons in their area. Section two provided a description of where homeless persons could be located, methods of approach, safety factors and names of other potential informants. These responses were especially helpful to the Regional and Field Coordinators as they made preparations to organize their interviewers for the Homeless Person Survey phase of the project. Section three, the Post Mortem, reflected the Coordinators' perceptions of the key informants being interviewed and was completed after each interview had been terminated.

The Homeless Person Field Survey Instrument Package

The final version of the Homeless Person Survey Instrument is a combination of items created especially for this study and existing items from scales used in psychiatric epidemiological research. The instrument underwent several reviews and revisions by project staff and experts knowledgeable about homeless people, and was pretested with homeless people in various parts of the state.

A number of problems/constraints influenced deliberations about the form and content of the Homeless Person Survey Instrument. First, the instrument had to minimize both the clinical demands of the interviewer and the response demands of the interviewee. As it was not possible to engage trained clinicians to interview 1000 people, principally because of cost prohibitions, the instrument could not include a psychiatric assessment that required such training. Also, the instrument needed to be simply worded, with relatively uncomplicated response sets, so that respondents could be engaged and held in an interview through its completion without it being a difficult or intrusive experience.

Second, it was critical that the instrument be able to assess psychiatric impairment and risk and that the scales used be validated and compatible with other general population research studies. The establishment of the prevalence of mental health disorder in this group requires that some comparison be made, either against a norm or against a contrast group of people. It was therefore necessary to focus on scales that had been used in prior epidemiological work to assure that such comparisons could be made.

Finally, the form and format of the interview schedule had to be adaptable to the generally non-clinical nature of the interview environment. Since our data collection plan required that homeless people be engaged in a variety of settings, some accommodating to interviews and some not, careful attention was given to the layout of questions, response sets and the construction of the instrument as used in the field.

Section I: Demographic and Life Experience Information. The first 56 questions in the interview schedule represent our efforts to understand various characteristics and experiences of homeless people. The topics covered are fairly broad and include such things as living arrangements, reason for being homeless, transience, use of social services or mental hospitals, employment history, medical concerns, social support and general well-being.

The development of items used in this section was an iterative process. We began with an extensive review of instruments that had been used in prior homeless studies. From that review, a pool of questions was generated and reviewed by research staff. The resulting reduced-item pool was then pre-tested on some homeless respondents to assess clarity and appropriateness. More review followed, with special attention paid to response structure and to interviewer "patter", that is, the script that was to be followed by the interviewer as he/she conducted the interview.

A second pre-test was completed which resulted in more modification. The number of items was reduced because of the lengthy nature of the interview and the response structure to certain items was changed. We decided that for some questions, the interviewer would not read the range of responses, but would rather circle the appropriate response based on the respondent's reply. For other questions, the range of responses was read to the respondent.

Section II. Psychiatric Status Schedule. A broad range of existing psychiatric assessment scales was reviewed during our deliberations about how best to assess mental status within the logistical and manpower constraints mentioned above. It was determined that the Psychiatric Status Schedule (PSS), developed by Robert Spitzer and his colleagues (1970), was our best choice given the tradeoffs that had to be made. The strengths of the PSS include: (1) a reasonably straightforward interview format that is structured to elicit information in an even, flowing way; (2) while structured, the interview is sufficiently flexible to facilitate establishing rapport; (3) items are nontechnical descriptions of small units of overt behavior, thus minimizing the need for extensive clinical inference; (4) symptoms/behavior coverage is broad; (5) psychometric properties have been established;

(6) extensive training materials are available, and (7) it has been used in other epidemiologic studies. In addition the PSS has been used by researchers in Ohio both in a large client tracking study and in a study assessing the impact of case management on aftercare clients, so that current Ohio norms are also available for comparison.

The full PSS has 321 items which are scored as true or false depending on the presence of the behavior indicated by a particular item. When scored, the instrument yields 17 first-level symptom scores, six first-level role scales, four second-level summary symptom scales and one summary role scale. The scales are simply sums across items with a weighting scheme included to indicate the differential impact of certain behaviors or characteristics on the symptom dimension.

During the course of instrument development we decided that, while the PSS would work well with homeless respondents from the standpoint of understandability, it would be likely that the interview would be too long. We therefore made the decision to use selected scales rather than the full PSS. The scales used were: 1) Depression-Anxiety; 2) Suicide-Self-Mutilation; 3) Speech Disorganization; 4) Inappropriate Affect, Appearance, Behavior; 5) Agitation-Excitement; 6) Interview Belligerence-Negativism; 7) Disorientation-Memory Impairment; 8) Retardation-Lack of Emotion; 9) Grandiosity; and 10) Suspicion-Persecutions-Hallucinations.

Our choice of scales was based on a couple of considerations. First, we wanted to measure dimensions that could be considered as indicators of deviant or different behavior, e.g. inappropriate affect, interview belligerence, agitation-excitement, speech disorganization, etc. Second, we wanted to use scales that were, in fact, proven indicators of subjective distress and reality testing. Researchers using the PSS have identified four scales (Retardation-Lack of Emotion, Suspicion-Persecutions-Hallucinations, Depression-Anxiety and Suicide-Self-mutilation) that were quite successful in discriminating between people who had demonstrated need for mental health services and people in the general community who had not demonstrated such need. Other researchers also contend that the PSS measures of delusions and hallucinations, suicidal tendencies and depression-anxiety can be used in epidemiologic research. Thus, ten scales in all were included in the PSS section to measure the subjective distress, reality testing and behavioral disturbance of homeless respondents.

We recognized that the above choices we made about psychiatric status instrumentation and measurement would place some limitations on study results. Probably the most important of these limitations was our inability to actually identify "cases", that is, to identify whether or not a respondent could be diagnosed as having a specific mental illness or problem. Being a case is generally thought to be a product of symptom configuration that must be assessed through a validated diagnostic instrument or through a clinical assessment performed by a licensed mental health practitioner. While the PSS was designed to yield a clinical diagnosis through the use of a computerized scoring program, our decision to use selected scales made computer scoring an impossibility. Also, the diagnosis generated by such scoring is based on outdated DSM-II criteria.

Our inability to identify cases, however, did not preclude our capacity to make some very important statements about symptom presence and prevalence among homeless people using PSS scores. First, we were able to describe symptom distributions in some detail on the domains measured. Also, by using cut-off scores established in previous work done with the PSS, we were able to identify and classify cases according to their clinical severity. Finally, our data permitted us to examine the relationship between psychiatric symptoms and various experiences, conditions and resources of homeless people.

Section III. Interview Post-Mortem. This section of the questionnaire contains items that are completed after the interview by the interviewers. These items are straightforward in content and include such things as one PSS item (shaking hands), county and region where the interview occurred, respondent characteristics (sex, ethnicity), and an assessment of the accuracy of respondent's answers.

Contact Log

In order to better understand the characteristics of the total sample of homeless persons contacted to participate in the study, it was necessary to find out as much as possible about those subjects who refused to be interviewed or who began the interview but subsequently refused to continue or were unable to complete it. Therefore, a one-page, 18-question log sheet was developed to record contacts with respondents who either (1) refused to be interviewed, (2) were screened out of the interview sample because they did not meet our definition of homeless, or (3) were unable to be interviewed at the time of contact. Interviewers filled out a log sheet whenever one of those three situations occurred. The questions addressed subject physical characteristics and overt behaviors.

A total of 172 contacts were made (72% in the afternoon or evening) that did not result in an interview taking place. Of those contacts, 65 (38%) were screened out as not meeting the criteria for being homeless. The remaining 107 people approached (62%) either refused to be interviewed or were unable (for a variety of reasons) to be interviewed. Of those who refused or were unable to be interviewed, 78 percent were men and 66 percent were white. Over one-half were between the age of 30 and 65. A little over one-half of them were described as having unkempt, tangled hair and clothes that were dirty or in disarray. On the whole, this group was not judged by the interviewers as being menacing, argumentative or sarcastic towards the interviewer. Twenty-eight percent were described by the interviewers as being drunk, mentally retarded or seriously mentally ill.

Mental Health Agency Survey Instrument

A brief data collection instrument was developed to collect information about individuals discharged from state psychiatric hospitals who were identified as homeless by community mental health agencies in the selected areas. The information collected through this instrument contains data for client identification (name and hospital identification number), the homeless condition category and a brief description of the homeless condition.

State Psychiatric Hospital Survey Instrument

An instrument was developed to collect monthly information about individuals identified as homeless after admission to state psychiatric hospitals. In addition to the information included in the previously mentioned instrument (patient identification data, homeless condition category, and the description of homeless condition), this instrument also contains information about the total number of admissions evaluated by the hospital and the total number of patients identified as homeless during the month.

Interviewer Training and Approach Techniques

To assure the careful and consistent use of the survey instrument, procedures for the selection and training of interviewers were developed. In each area of the state, regional coordinators selected a cadre of interviewers. Most of the interviewers were from the major urban counties where the majority of interviews were to be conducted, however local interviewers were used in some of the mixed and rural counties. Interviewers were selected for their ability to engage subjects, be comfortable in places where homeless persons could be found, develop rapport with the subjects and carry out the interview format. All interviewers had a bachelor's degree, and most had education and experience in the social sciences. They also were made up of both men women, people in young and middle adulthood, and those representing white and minority racial groups. In all, 42 interviewers were used.

An extensive training manual was prepared, and a four-hour training session was conducted in each region by the Project Coordinator and a training team. One member of the team had had extensive experience in use of the Psychiatric Status Schedule in previous research.

Training content covered techniques for approaching homeless people in street settings, shelters, community kitchens, and public facilities; engagement strategies; standard responses to most anticipated questions and ways to interpret and probe in the course of the interview. Interviewers were also given careful instructions on safety precautions, ethical considerations of confidentiality and informed consent, and legal considerations around revelations of criminal behavior, particularly child abuse. In addition, interviewers were given information about referral agencies for persons who had severe mental or physical health care needs or appeared suicidal.

Interviewers also watched a role-play of a typical interview, with specific attention to the Psychiatric Status Schedule of the instrument. This helped interviewers to understand problematic responses which might be anticipated.

Interviewers were instructed to select and approach homeless people in different ways in different settings. For example, while random selection was a major concern in shelters, identification and approach were easy since the circumstances clearly marked the potential subjects as homeless. On the other hand, deciding who was a homeless person and then engaging that individual in a public park or diner took quite a different technique. One could not assume people were homeless just because they had a certain appearance.

Interviewers were trained to be casual, sensitive, and kind in chatting with potential subjects, especially in environments where the subjects were not obviously identified as homeless people. They were told to slip into a conversation about where the prospective subject lived, etc.

In instances where there were many potential homeless subjects (in a soup line or in a shelter, for example) random procedures were used. For example, an interviewer in a shelter might approach every tenth sleeping mat and ask that particular person to participate in the interview. In rural areas, an attempt was made to engage and interview every homeless person that was identified. Once rapport had been established, it took approximately one hour to complete the formal interview instrument. Many subjects enjoyed the chance to express their feelings, and therefore many interviews took longer than one hour.

KEY INFORMANT SURVEY RESULTS

In our study we planned to locate Key Informants in each of the geographical areas in which personal interviews with homeless people were to be undertaken. Our procedure for selecting and interviewing Key Informants involved initial telephone contacts with those persons who ought to, by virtue of their position, have some knowledge of homeless people in their community. These included: soup kitchen operators, emergency shelter agency directors, clergy, mental health agency directors, social workers, law enforcement officers, and welfare agency workers. We also talked with bartenders, all-night laundromat operators, bus station managers, park rangers, health inspectors, postal workers, school bus drivers; in short, anyone who might encounter homeless people.

Several hundred Key Informants were contacted. Those having information of relevance to the project were asked to participate in a personal or telephone interview lasting anywhere from 30 minutes to one hour. Most initial Key Informant contacts were periodically followed up during the course of the study.

Completed Interviews

By the conclusion of the Key Informant Survey phase of the project, a total of 164 Key Informants, 83 (50.6%) from urban counties and 81 (49.4%) from non-urban counties, had been interviewed. Table K1 shows the breakdown of interviews by region and type of county. A relatively equal number of interviews was obtained in each of the regions, except for the Southeast Region, where only 15 (9.1%) interviews were obtained. This reflects the sparse population of the four sample counties in that region and the small numbers of people who work with or are knowledgeable about homeless people in their communities.

Table K1

Completed Key Informant Interviews by Region
and Type of County

REGION	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Northeast	28	33.7	17	21.0	45	27.4
Southeast	0	0.0	15	18.5	15	9.1
Central	23	27.7	17	21.0	40	24.4
Northwest	24	28.9	11	13.6	35	21.3
Southwest	8	9.6	21	25.9	29	17.7
Total	83	99.9	81	100.0	164	99.9

The 164 Key Informants who were interviewed were classified as working in one of nine agency/service categories: law enforcement, community chest, hospital emergency rooms, religious organizations (including the Salvation Army and Volunteers of America who operate shelters for homeless people), homeless agencies and shelters (non-religious), Mental Health Boards and agencies, Welfare and/or Children's Services, cheap hotels and motels, and other (bartenders, Health Department personnel, postal workers, etc.).

Overall, the largest group of Key Informants (29.3%) came from religious organizations, followed by Welfare and/or Children's Services (15.2%) and Community Chest (12.2%). This pattern is only slightly varied across regions. See Table K2.

Table K2

Completed Key Informant Interviews by Region and Service/Agency Category

SERVICE/AGENCY	NE		SE		C		NW		SW		TOTAL	
CATEGORY	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Law enforcement	3	6.7	1	6.7	4	10.0	4	11.4	0	0.0	12	7.3
Community chest	5	11.1	2	13.3	3	7.5	3	8.6	7	24.1	20	12.2
Hospital emergency rooms	0	0.0	1	6.7	4	10.0	1	2.9	1	3.5	7	4.3
Religious organizations*	17	37.8	5	33.3	7	17.5	15	42.9	4	13.8	48	29.3
Homeless agencies (non-religious)	2	4.4	0	0.0	3	7.5	0	0.0	2	6.9	7	4.3
Mental Health Boards/ agencies	4	8.9	2	13.3	4	10.0	5	14.3	4	13.8	19	11.6
Welfare/Children's services	7	15.5	3	20.0	6	15.0	4	11.4	5	17.2	25	15.2
Cheap hotels/motels	2	4.4	0	0.0	2	5.0	2	5.7	1	3.5	7	4.3
Other**	5	11.1	1	6.7	7	17.5	1	2.9	5	17.2	19	11.6
Total	45	99.9	15	100.0	40	100.0	35	100.1	29	100.0	164	100.1

* Includes shelters and missions operated by such groups as the Salvation Army, Volunteers of America, etc., and church-operated soup kitchens.

** Includes the media, group homes, health departments, battered women's shelters, and private homes.

There are differences when one looks at the types of Key Informants interviewed in urban counties versus those interviewed in non-urban counties. People who work with religious organizations represented (39.8%) of all Key Informants interviewed in the urban counties. This is a result of active church participation in the operation of soup kitchens and emergency shelters for homeless people in urban areas. The rest of the urban interviews were rather equally distributed between the other eight agency/service categories. In contrast, Welfare and/or Children's Services represented 22.2 percent of all Key Informant interviews in the non-urban counties, followed by religious organizations (18.5%), and Mental Health Boards and agencies (16.0%). See Table K3.

Table K3

Completed Key Informant Interviews by County and Service/Agency Category

SERVICE/AGENCY CATEGORY	URBAN Number	URBAN %	NON-URBAN Number	NON-URBAN %	TOTAL Number	TOTAL %
Law enforcement	7	8.4	5	6.2	12	7.3
Community chest	9	10.8	11	13.6	20	12.2
Hospital emergency rooms	3	3.6	4	4.9	7	4.3
Religious organizations*	33	39.9	15	18.5	48	29.3
Homeless agencies (non-religious)	5	6.0	2	2.5	7	4.3
Mental Health Boards/agencies	6	7.2	13	16.0	19	11.6
Welfare/Children's services	7	8.4	18	22.2	25	15.2
Cheap hotels/motels	5	6.0	2	2.5	7	4.3
Other**	8	9.6	11	13.6	19	11.6
Total	83	99.9	81	100.0	164	100.1

* Includes shelters and missions operated by such groups as the Salvation Army, Volunteers of America, etc., and church-operated soup kitchens.

** Includes the media, group homes, health departments, battered women's shelters, and private homes.

Key Informant interviews solicited three kinds of information represented by the following questions:

1. What are the characteristics of homeless people and how prevalent is the problem of homelessness in the respondent's community?

2. What are the human service needs of homeless people and how well is the community (or agency) meeting these needs?

3. Where are homeless people to be found in the community and what is the best way to approach them in order to successfully complete an interview?

Characteristics of Homeless People

Few Key Informants with whom we spoke were able to authoritatively identify the characteristics of different types of homeless people and their prevalence in the community. In general, urban formal service providers not involved with direct client services to homeless people knew little about the homeless population. Most were surprised that their organizations would be asked about the problem. This was not so much the case with those in non-urban systems. Perhaps the large client loads and professional orientations of the urban Key Informants, as compared with the smaller client loads, fewer homeless people, and the personalized nature of services in the non-urban counties accounted for urban/non-urban differences.

Those directly involved in services to homeless people tended to focus in on a specific kind of problem/characteristic of only some groups, but not all. For example, service providers operating soup kitchens perceive the homeless population to be largely composed of transients, poor people, and an occasional unemployed person "at the end of his rope". They do not see them as female single parents who have been abused and/or abandoned by their spouses. Because of this often limited perspective, their responses to the following questions, which asked for specific numbers and percentages, should be treated with caution.

Question: How many homeless people are there in your area?

When asked this question, almost one-fourth (24.3%) either said they did not know or did not answer the question. For those who answered, there was great variability, and responses ranged from zero homeless people to 10,000.

Question: How many homeless people were there in your community two years ago?

Again, the range of answers went from zero to 10,000 homeless people. However, 41 people (25.0%) said that they did not know the exact figure but that there were fewer homeless people two years ago than now. Another 29 people (17.7%) said they had no idea or did not answer the question. Only three people (1.8%) said that there are fewer homeless people in their area now than two years ago.

Question: What is the sex of homeless people?

Answers ranged from zero percent female to 100 percent female and, correspondingly 100 percent male to zero percent; and 15.8 percent said they did not know. Most respondents, though, felt there were greater percentages of males. Respondents' answers are affected by the type of agency they work in. For example, individual social workers working in non-urban county Welfare offices may say that all of the homeless people they know of are women with small children.

Question: What is the race of homeless people?

Most respondents indicated that homeless people in their area tended to be white. Only one respondent said that zero percent of the homeless population were white, while 21 respondents (12.8%) said that 100% of homeless people in their area were white. Almost 16 percent said that zero percent of the homeless population is Black, and 14.6 percent of the respondents said they did not know or did not answer the question.

Question: What is their age?

The response categories for this question were difficult to analyze, however, none of the respondents indicated that zero percent of homeless people were under the age of 30, in contrast to 21 respondents (12.8%) who said that zero percent of the homeless in their area were over the age of 65. Thirty-five of the respondents (21.3%) said they had no idea about the age ranges of homeless people.

Question: How many are employed?

Over one-third (35.4%) of the respondents said that zero percent of homeless people are employed. In contrast, one respondent said that 100 percent of homeless people in their area are employed. Thirty respondents (18.3%) said they did not know and/or did not answer the question.

Question: What is their educational level?

Because of the large number of response categories and unclear wording, it was not possible to correctly analyze the data. It was apparent, though, that most respondents thought that the majority of homeless people had at least some grammar schooling and that very few had been to college.

In summary, Key Informants tend not to be knowledgeable about the demographic characteristics of the homeless population. As might be expected, they perceive the overall phenomenon of homelessness primarily in terms of the groups of people with whom they work most directly.

Human Service Needs of Homeless Persons and the Effectiveness of Community Programs to Meet These Needs.

Key informants were more adept at identifying many of the major problems experienced by homeless people and their human service needs than they were at identifying their demographic characteristics. Many appeared knowledgeable about what services were already available in their respective communities and the effectiveness of those services. Below are their responses to questions dealing with reasons for homelessness, the major problems and service needs of homeless people, and how their communities can make existing services more effective in meeting the needs of homeless people.

Question: In your opinion, what are the major reasons why people are homeless in your area?

Central Region. A variety of reasons were listed as being the major reasons for homelessness, although economic factors were most often cited. In Franklin County, the majority of Key Informants suggested unemployment as a major reason for homelessness, especially for homeless families, and particularly those headed by women. Other closely related causes for homelessness of families is family violence and inadequate benefits resulting in evictions.

Deinstitutionalization and other mental health problems were mentioned by about one fourth of the respondents, but a less definitive mental health diagnosis was noted by more than half of the respondents, i.e., inadequate social adjustment and personality disorders. These homeless people were described as unable to cope with the demands of daily living, unable to find out about services and benefits for which they were eligible, and lacking in self-esteem and hope. Less often named as a cause was substance abuse. About one-fifth of the respondents noted alcohol as a reason why people are homeless.

In the three non-urban counties of the Central Region, economic factors were most often cited as the major reason for homelessness. These factors include unemployment, underemployment, financial need, and the inability to pay high rents. The next most often cited factors were those related to the family, i.e., family conflict, lack of family support, and inability to cope with family stress. A few Key Informants also noted lack of training/education, poor coping/social skills, transience, mental and physical handicaps, releases from Veteran's Administration hospitals, and alcohol abuse.

Southwest Region. No one reason was cited more often than others as being the major reason for homelessness in Hamilton County. The variety of responses given by Key Informants included poor family support, lack of social and living skills, insufficient low-cost housing, disaster, drug and alcohol problems, mental health problems, and deinstitutionalization.

Economic factors were cited by the vast majority of Key Informants in the non-urban counties as the major reason for homelessness. The next most cited reason was the lack of low-cost and/or public housing. Inappropriate social/living skills and transient life style were also frequently cited.

Southeast Region. As was the case in the Southwest and Central Regions' non-urban counties, Key Informants in the Southeast Region cited economic factors/unemployment as the major reasons people are homeless in their areas. Transiency and family trauma were also listed by five Key Informants (33%) as a major reason for homelessness. Two informants said that homeless people in their area are homeless because "that's the lifestyle they want."

Northwest Region. In Lucas County the majority of Key Informants cited deinstitutionalization as the major reason why people are homeless. Other major factors cited were economic problems, especially unemployment, alcohol or drug involvement, lack of affordable housing, shunning by family and friends, lack of public shelter, eviction, inability to penetrate the service network, lack of advocacy, and chosen lifestyle for some.

Again, in the non-urban counties, economic factors including unemployment, high rents, and eviction were listed as the major reason for homelessness. Transiency, alcohol abuse, and deinstitutionalization were also mentioned.

Northeast Region. In Cuyahoga County many factors were identified as reasons for homelessness, including termination of government benefits, reductions in benefit amounts, tightening of welfare policies, Reaganomics, and the idea that government benefits were "too low". In this regard, general relief was most often identified. Underemployment was identified as well as unemployment. Other reasons given included: utility cut-offs, not enough caring people, unavailability of low income housing, inability to cope, poor education, eccentricity, and poor money management. Overall, there seemed to be the sense that most respondents blamed "society", the "government", or the "social structure" for homelessness. According to the responses by most Key Informants, primary culpability seems to lie with systems outside the homeless person.

Only one reference was made to transiency, and in the context of "mentally disturbed people are attracted to this area because of the many churches and centers for the homeless". Otherwise, "transience" was not considered to be a reason for homelessness in Cuyahoga County.

The respondents in the non-urban counties cited transiency, economic factors and family problems as the major reasons for homelessness in their counties. However, many respondents made a distinction between transient homeless people and local homeless people.

The major reason given for transient people's homelessness was that they are "vagabonds," while local homeless people are homeless due to many outside factors, i.e., termination of government benefits, family conflict, eviction or lay-offs.

Question: How important do you feel the following factors are in contributing to homelessness in your area?

Respondents were then asked to rate several factors on a scale of 1 to 4, with 1 being extremely important. Unemployment (mean=1.6) was identified as the most important reason, followed by family conflict (mean=1.9). The results of these overall ratings by

Key Informants are parallel to responses given by them to the preceeding question, which asked their opinion about the major reasons why people are homeless. See Table K4.

Table K4

"How important do you feel the following factors are
in contributing to homelessness in your area?"
(N=164)

FACTORS	Mean	Number of Respondents	% of Total
Unemployment	1.6	155	94.5
Family conflict	1.9	155	94.5
Alcohol/drug abuse	2.0	152	92.7
Psychological disorder	2.2	154	93.9
Eviction	2.2	153	93.3
High rents	2.2	152	92.7
Deinstitutionalization	2.2	150	91.5
Government benefits stopped	2.3	148	90.2
Transience as chosen life style	2.7	149	90.9
Uninhabitable home	2.9	145	88.4
Disaster	3.3	154	93.9

Scale

1 = extremely important
2 = important
3 = not important
4 = not at all important

Question: In your opinion what are the major problems experienced by homeless persons in your area?

Central Region. By and large, most of the Franklin County Key Informants identified the homeless person's loss of self-esteem, self-contempt, depression, fear and overall low functioning as his/her major problem. Most also noted physical health care needs and need for basic shelter. Other problems, each noted by about one-fourth of the informants, included safety, jobs, and mental health problems. Key informants working more with family evictions and directly with housing noted the problem of having to split up the family in order provide shelter.

In the non-urban counties, the problems most often cited were finding housing, getting medical care and finding jobs. Informants noted that rents had increased in Union County since the Honda Plant was built. Some Key Informants also cited the need for a community sensitive to the needs of homeless people and a coordinated effort to supply basic necessities, perhaps through an improved welfare system.

Southwest Region. In Hamilton County a wide variety of problems were cited including day-to-day survival (finding shelter and food), lack of adequate alcohol abuse and medical treatment, alienation from meaningful relationships and poor coping skills, including lack of awareness of available resources. Insufficient affordable housing was also cited.

In the non-urban counties the major problems cited were economic factors, i.e., inability to pay utility bills, ineligibility for government programs because of no permanent address, inability to pay high rents and the lack of emergency housing. The next most noted problems centered on the homeless person's feelings of worthlessness, depression and overall lack of family support and alienation from others. Poor coping skills were also mentioned, as was the problem of not having anything to do with one's time. Finally, one respondent mentioned the problem with the public's attitude, i.e., "get the homeless out of our town."

Southeast Region. Key Informants overwhelmingly noted that lack of the "basics" and not having enough resources (income, people to turn to, access to programs) were the major problems experienced by homeless people in their area. Lack of transportation, no emergency assistance, community attitudes (the idea that homeless people should be able to "pull themselves up by their bootstraps"), lack of affordable housing and the general lack of facilities in small communities were also mentioned.

Northwest Region. When asked about the major problems faced by homeless people in Lucas County, most Key Informants, as in other regions, cited survival--finding shelter, food and heat. In addition, they mentioned the problem of inaccessability to services without having a permanent address, health problems, the need for a bath and access to public facilities, case management, and advocacy. One Key Informant mentioned the problem that homeless people are more prone to be victims of crime than perpetrators.

In the non-urban counties of the region the lack of transportation was cited as a problem. This is also a problem that has been mentioned in other non-urban counties. Additionally, problems such as financial and legal assistance were noted, as well as the lack of food and medical treatment.

Northeast Region. In Cuyahoga County the respondents seemed to feel that the major problems of homeless persons bore a close relationship to the reasons they were homeless. Lack of low income housing, jobs, long-term shelters, early release from hospitals, and lack of incentives were all cited. Psychological problems such as depression, psychosis, and emotional difficulties also ranked high on the list. Dehumanization of "the system" was indicated, as some homeless persons are said to be unprepared for community living due to rapid deinstitutionalization, loss of citizen rights, lack of skills, and the inability to handle money. In one case, short-term shelters were labeled a problem because "people can't get it together in so little time."

As mentioned elsewhere, the lack of an address, necessary to obtain welfare benefits, was mentioned to be a problem for some homeless people in the non-urban counties. Emotional problems came up also, such as depression, anxiety, confusion and the feeling of not knowing where one's next meal is coming from or where one is going to sleep. Key Informants also mentioned the problems of alcohol, medical problems and negative community attitudes towards homeless people.

Question: In your opinion, what percent of the homeless population in your area experience the following problems?

Key Informants were asked to give their opinion about what percent of homeless people suffer from acute physical problems, chronic health problems, psychological problems, and alcohol and drug abuse. There was an extremely wide range of responses from Key Informants--in some cases from zero percent to 100 percent--on all items. Psychological problems were given the highest occurring rates (median=60%) followed by alcohol abuse (median=40%). See Table K5.

Table K5

"In your opinion, what percent of the homeless people in your area experience the following problems?"
(N=164)

PROBLEM	Percentage Range	Median	Respondents No.	Respondents % of Total
Psychological problems	2% - 100%	60%	133	81.1
Alcohol abuse	0% - 90%	40%	134	81.7
Chronic health problems	0% - 100%	35%	129	78.7
Drug abuse	0% - 80%	25%	124	75.6
Acute physical problems	0% - 100%	20%	128	78.0

Question: What do you personally feel are the most needed services for homeless persons in your area?

Southwest Region. Affordable housing and emergency shelters were the most frequently cited needed services in Hamilton County. One Key Informant mentioned a system of "getting rental vouchers from Welfare so people don't need a fixed address." Two other Informants noted a need for case management in order to assist people in finding community resources.

By far the most frequently needed service cited by Key Informants in the non-urban counties was emergency shelters. The two next most frequently needed services were cheap housing and counseling and/or mental health centers. Three informants also mentioned the need for a central coordinating service agency to help homeless people.

Southeast Region. The "basics" (shelter, food and clothing) were cited by the majority of Key Informants in this region as being the most needed services. Emergency shelters, shelters for homeless women, and an adequate supply of affordable housing were stressed. Additionally, medical services, drug and alcohol rehabilitation, outreach follow-up of individuals released from psychiatric hospitals, and counseling were cited by a few.

Northeast Region. In terms of services most needed, Cuyahoga County Key Informants reported affordable housing, safe emergency shelters, food, medical and mental health services, better facilities, and increased income. However, there were several comments supporting a need for a centralized and better coordinated service network, a better referral network, a resource bank, and outreach programs. Commitment by agencies to serving homeless people was said to be needed, as well as caring adults in the community. Most often, indications for increased services were coupled with allocation of responsibility for funding to the federal government.

A wide variety of services were mentioned in the non-urban counties. In one county, organization--"someone assigned specifically to aid the homeless"--and advocacy were suggested. In other words, the need was for a human service system, not a building or program. Other respondents mentioned job assistance, mental health services, vocational training, counseling, transporation, and as always, more affordable housing.

Northwest Region. Lucas County respondents noted a need for many of the services identified in other regions, i.e., shelter, health and medical care, counseling, advocacy, case management, and jobs. One person cited "protection from their own naivete." Another mentioned friendship.

Non-urban county respondents uniformly suggested public sleeping shelters or missions and economic aid in the form of money, lower rents, and lower utilities.

Central Region. Most Franklin County respondents discussed the enormity of the problem and the difficulty of giving a comprehensive solution. One said, "too big a problem—can't get a grip on it". A few respondents provided broad-based solutions which include a continuum of shelter care from "mattress warehouses" to low cost permanent housing with comprehensive human services, coordinated across types of service and levels of human need. Stressing the multiplicity of the problems of homeless people and the varieties of their needs, many emphasized integration of mental, physical and substance abuse health care services offered in a secure environment before, or as a foundation to, education and job counseling to cure unemployment problems. Key Informants also identified the city's relatively small component of low cost housing as a problem and stressed that homeless people need affordable housing, adequate income supports and, where these have failed, they need shelters. Where families are concerned, each of these resources was indicated to be in shorter supply and a pressing community need.

Key Informants in the non-urban counties of the Central Region had similar responses to other non-urban county respondents. Most often mentioned were emergency shelters and low-cost housing. Also cited were 24-hour referral services, social services to reestablish family connections, and emergency services provided by an aware, caring community.

When synthesizing what Key Informants cited as being the major service needs of homeless people, it is clear that emergency shelters and low-cost housing are viewed as the most pressing. Many respondents feel that without attending to this most basic need, other services will not have a maximum impact.

Question: In your opinion, how needed are the following services for homeless people in your area?

As a follow-up to the preceeding question, Key Informants were asked to rate the need for the following services: soup kitchens/food pantries, shelters for homeless people, emergency rooms, mental health services, financial help, job-finding assistance, medical treatment and housing assistance. Shelters and housing assistance were rated the most needed. These ratings reinforce respondents' answers to the preceeding question in which, overall, the provision of shelter/housing was perceived as the most needed service for homeless people. See Table K6.

Table K6

"In your opinion, how needed are the following services
for homeless persons in your area?"
(N=164)

SERVICES	Mean	Number of Respondents	% of Total
Shelters for homeless people	1.4	149	90.9
Housing assistance	1.4	148	90.2
Financial help	1.6	148	90.2
Soup kitchens/food pantries	1.7	150	91.5
Mental health services	1.7	146	89.0
Job-finding assistance	1.8	147	89.6
Medical treatment	1.8	146	89.0
Emergency room services	2.0	143	87.2

Scale

1 = very needed
2 = needed
3 = not needed
4 = not needed at all

Question: Are the following services now being provided to homeless people in your area?

Key Informants were asked to indicate if eight different social services were currently available to homeless people in their area by answering yes or no. See Table K7 for a listing of these services. While 75 percent of all respondents said soup kitchens/food pantries exist in their area, caution should be used in interpreting this percentage, as the two services are mutually exclusive. Each of the eight services was said to exist in their area by at least half of all respondents. Mental health services were cited as the most frequently provided service (82.3% of the respondents said yes), followed by emergency room services (75.6%).

Table K7

"Are the following services now being provided
to homeless people in your area?"
(N=164)

SERVICES	YES		NO		No Answer	
	No.	%	No.	%	No.	%
Mental health services	135	82.3	10	6.1	19	11.6
Emergency room services	124	75.6	18	11.0	22	13.4
Soup kitchens/food pantries	123	75.0	22	13.4	19	11.6
Medical treatment	106	64.6	35	21.3	23	14.0
Financial help	105	64.0	35	21.3	24	14.6
Job-finding assistance	96	58.5	42	25.6	26	15.9
Shelters for the homeless	95	57.9	51	31.1	18	11.0
Housing assistance	83	50.6	56	34.1	25	15.2

Question: How effective do you think these services are in meeting the needs of homeless people in your area?

After being asked whether or not specific services existed in their communities, Key Informants were then asked to rate the effectiveness of these services. On a scale of 1 to 4 (with 1 equal to very effective), Key Informants rated soup kitchens/food pantries (mean=1.9) as the most effective services for meeting the needs of homeless people, while job-finding (mean=3.3) and housing assistance (mean=3.2) were viewed as being the least effective. These results should not be startling. It is easier and cheaper to provide food for people than to find jobs or low-cost housing that may not exist in a particular community. See Table K8.

Table K8

"How effective do you think these services are in meeting the needs of homeless people in your area?"
(N=164)

SERVICES	Mean	Number of Respondents	% of Total
Soup kitchens/food pantries	1.9	125	76.2
Emergency room services	2.4	117	71.3
Mental health services	2.5	127	77.4
Medical treatment	2.6	107	65.2
Shelters for the homeless	2.6	104	63.4
Financial help	2.9	114	69.5
Housing assistance	3.2	104	63.4
Job-finding assistance	3.3	113	68.9

Scale

1 = very effective
2 = effective
3 = not very effective
4 = not at all effective

Question: How could existing services be made more effective in meeting the needs of homeless people in your area?

Central Region. Comprehensive plans were suggested by Franklin County respondents. Some components which were identified by more than one respondent were: total community awareness and commitment, support from both public and private service sectors, increased cooperation between professional human service providers and grass roots service providers, integration of services, assessment and referral in shelters, and increased outreach to shelters and streets.

Many Key Informants stressed the need to increase the amount of low-cost housing available. Those who work primarily with family units again stressed the need for more services for families.

Many very knowledgeable Key Informants noted that the community must recognize that some percentage of homeless people are not rehabilitatable, but will need on-going care for their dependence either in institutions or in the community. An idea which emerged from a number of informants involved assessment and initiation of multiple services in the shelter setting. Caseworkers should manage the advocacy and brokerage that links the individual to needed income, mental and phsyical health care, etc.

Key Informants in non-urban counties in the Central Region agree that services would improve with the provision of emergency assistance and shelter. For example, in one county the sheriff sends homeless people to the Welfare Department or the Salvation Army representative. Also, the system in all counties could be improved by having some central agency in charge of coordinated referral.

Northwest Region. In Lucas County, respondents suggested the following: loosening of eligibility standards and reducing red tape, inter-agency coordination, more staff at the Welfare Department, allowing people to get welfare without a permanent address, and longer open hours for social service agencies. Eviction usually occurs between 5:00 p.m. and 10:00 p.m., when agencies are closed.

Like many respondents in other non-urban counties, the Key Informants from Wood, Paulding, and Fulton counties mentioned the need for more centralized coordination among agencies that serve homeless people.

Northeast Region. Most Cuyahoga County Key Informants suggested increasing their funding and creating a single organization that "should take responsibility for providing help to the homeless". While there were many calls for increasing funding and centralized services, there was also a call for a reduction in government "red tape," reductions in salaries of "program sitters," and "restrictions on federal money." All of this seems to point to an expression of the need for greater control where it benefits homeless programs and persons. Many of the comments showed contempt for the inadequacy of existing services, "the free night at the _____ Hotel--compliments of the County--I wouldn't let my dog sleep there."

According to many non-urban respondents, making services more available, more attractive, and better known through the community are the chief ways of making services more effective for homeless people. An emphasis was placed on quality of service, i.e., proper funding, decent counseling, and providing more individualized help. On one hand, respondents in one county consistently voiced concern over how to improve services without attracting "more homeless people to stay." On the other hand, there was an acknowledgement that "what's available isn't sufficient for the need." One respondent said that emergency housing assistance could be made more effective if there were more low-cost housing.

Southeast Region. The three most cited suggestions for improving existing services were more public education, central referral including increased inter-agency cooperation, and more services and facilities. Some respondents said that there was too much "overlapping" of programs; another said that existing programs just are not fully implemented. One respondent mentioned too many regulations and paper work.

Southwest Region. Hamilton County respondents mentioned better coordination among service providers as a way to improve existing services. Two respondents said that services probably could not get better as "homeless people can not/do not want to change their living situation." More resources for families and low-cost housing, especially for the elderly, were noted.

Non-urban respondents overwhelmingly mentioned the need for better coordination between agencies. Three said that professionals must take responsibility for their jobs. The provision of more shelters was also mentioned by a few.

Question: Is there a formal referral network among organizations in this county (area) for meeting the needs of homeless people? If yes, please explain. If no, how do you deal with homeless persons in your county (area)?

When asked if there was a formal referral network among organizations in their area for meeting the needs of homeless people, 42.1 percent said yes, 40.8 percent said no, and 17.1 percent either did not know or did not answer the question. When their answers were analyzed in detail, it was determined that Key Informants characterize a community helping network as having a formal service provision and an informal caregiving component. Formal services were defined as 1) soup kitchens, emergency shelters, longer-term shelters, 2) program-specific services such as alcohol or drug abuse, mental health, employment services, etc., and 3) more comprehensive services such as Welfare, Salvation Army, Veteran's Administration, etc. Informal caregiving included: family and relatives, private concerned-citizen activities (occasional room and board, clothing, etc.), and homeless people self-help groups. The array of these services is primarily dependent on community size.

Non-Urban Systems. Non-urban Key Informants perceive their systems to be targeted almost exclusively to local homeless residents, as opposed to transients or outsiders. Transients or outsiders are usually encouraged, often by force, to move on to urban areas. This is accomplished by providing bus fare to the nearest city, arresting persons until deportation can be executed, "rousting" persons from public and private places, and offering or providing few, if any, helping services. Non-urban places are hostile to homeless outsiders.

By contrast, indigenous homeless people are treated much better. Family and friends assume most of the burden for taking care of these individuals. Often, this responsibility is shared by shuttling the person (or family) along from family to family as their "welcome" is exhausted. Where families are unable to meet the basic needs of homeless people, churches emerge, especially by providing food and clothing, and sometimes shelter or transportation. Importantly, churches also act as brokers for homeless people by finding ways to provide basic needs and, in some cases, jobs. There are no self-help groups among non-urban homeless people, primarily because of existing community support systems.

Formal service provision in non-urban areas is quite limited. The capacity of small populations to support comprehensive human service programs is not great. In non-urban areas, those agencies which are present in communities work on behalf of homeless people, even though it may not be a service they are required to provide. Welfare workers, public health inspectors, county sheriffs, Red Cross staff, United Way officials, and others, for example, may become aware of a homeless person who needs help. These service providers all have a highly developed informal network in which telephone calls are made to activate the system. Eventually someone in the network is able to resolve the problem or need. This system works because most of the service providers know one another and, importantly, in many cases also know the homeless person.

The formal and informal system configuration make it difficult for a homeless person to "fall through the cracks" in meeting basic human needs. The most significant problem faced by the system is that it does not have the full array of social or human service programs to treat specialized needs. The capacity to deal with mental health, alcohol and drug abuse, diagnostics and testing, children's and family's services, etc., are limited, although programs exist to some degree.

Urban Systems. Urban Key Informants perceive their systems as designed (or having evolved) to serve not only local people, but also transients and outsiders. In fact, both urban and non-urban Key Informants view urban areas as "catch basins" for outcasts from other urban areas and non-urban places.

Urban systems appear to Key Informants to have much less highly-developed informal caregiving networks. The absence of family ties and an eroded sense of community seems to inhibit the incubation of this kind of system. Ironically, whereas in the non-urban system, homeless person self-help groups are rare, quite the opposite is the case in urban environments. It is common for small groups of homeless people to travel and work together, and even more likely to act as sources of information about food, shelter, and jobs.

Urban systems are characterized by their complement of formal service agencies. Importantly, only a few of these are specifically targeted to meet the needs of the homeless population, either as their primary or secondary mission. Mental health centers, hospitals, housing offices, Welfare, employment services, and others see relatively few homeless people, either because of eligibility requirements (e.g., permanent address, residency, etc.) or because certain homeless people avoid or cannot deal with the formal system. In addition, few of these agencies have any outreach programs in place to attract homeless clients. Agency services are perceived by Key Informants to be targeted toward indigenous poor people or special client groups, neither of which typically includes homeless people.

Organizations which serve homeless people are perceivd as more or less meeting basic needs such as food, shelter, and clothing, but as in non-urban areas, specialized problems are rarely dealt with. There appear to be few linkages between the comprehensive formal service providers and the homeless-specific programs. Key Informants in the comprehensive service field believe that their programs are not directly relevant to the homeless population as clients, and their caseloads of "traditional" clients already tax the system. Those working in programs for homeless people believe that linkages could be made, but that comprehensive service providers do not wish to make them. Homeless service providers often see themselves as working in a field where there exists a major problem, which is met with indifference by other service providers and the community generally. Others in the human service system seem to be perplexed about what to do about the problem, but more importantly, some appeared to be hostile toward homeless people as clients, and seemed to believe they were homeless by choice or through their own fault.

Mixed Systems. Mixed areas, those with small cities and large tracts of rural land, are thought of as falling somewhere between the extremes of a non-urban/urban continuum. The mixed system is large enough to have urban problems, but too small to create a fabric of services to comprehensively deal with them.

In the case of transients and outsiders, mixed systems are viewed by Key Informants as intermediate stops along the way to urban areas. Services are available for the needs of homeless people of this kind, unlike non-urban areas. Beyond this service, the mixed system tends to have some of the same problems in making connections between comprehensive services and those targeted toward homeless people.

Although formal service provision is not as grandiose in the mixed areas, it functions much like the urban formal systems. However, the informal system appears to be more like the non-urban: local people taking care of themselves.

Locating Homeless People and Approach Strategies

Key Informants were asked to identify potential sites where homeless people could be found and interviewed. The responses given by Key Informants varied according to whether they were from urban or non-urban counties, and according to whether they were directly involved in working with homeless people or not.

In the urban areas, most Key Informants suggested going to soup kitchens and emergency shelters to find homeless people (generally men). Many also gave the names of cheap hotels. It was indicated that many homeless women would most easily be located by going through a third party, i.e., Welfare/Children's Services or religious organizations. Most Key Informants in urban areas felt there would be no problem in locating homeless people to be interviewed.

Non-urban Key Informants were less optimistic about finding homeless people to be interviewed, some even insisting that homeless people do not exist in their counties. Homeless people would be hard to locate, they indicated, because they are more hidden (in a park, for example), do not congregate in groups (as in an urban soup kitchen), their numbers are small, and because many are often forced to leave the non-urban county to seek services in urban areas.

Key Informants not working directly with clients who are homeless proved to be of little assistance in locating homeless people, except in that they were able to provide generalized information about soup kitchens, city parks, emergency shelters, etc. Key Informants working with homeless groups, by contrast, were able to identify potential respondents receiving public services, but were less accurate in guiding interviewers to other sites not directly associated with their efforts. This finding suggests that most homeless people are or can be nearly invisible to much of the formal service system in communities, as may be the case with poor people generally.

Those cases where Key Informants were most helpful tended to be ones in which the Key Informant directed interviewers to someone else who knew where to find homeless people who were not obviously receiving public services such as sleeping at a shelter or standing in a line at a soup kitchen.

In general, with few exceptions, Key Informant responses eventually yielded a comprehensive list of sites at which homeless people might be found in each region. But, except for soup kitchens and emergency shelters, most of the sites yielded few numbers of interviews. All other interviews were completed with considerable effort on the part of interviewers.

As to approach strategies and safety considerations, most Key Informants indicated that homeless people are generally passive and not dangerous, and that foul language would be the most negative response. It was suggested that interviewers dress causally, offer cigarettes or a cup of coffee to potential respondents, and act professionally. However, it was suggested by some Key Informants that interviewers not press homeless people who appear to be resistant or hostile, and that interviewers should not carry much money on their person.

Summary/discussion

Key Informants were, by and large, unable to identify characteristics of the overall homeless population in their communities. Where they worked directly with segments of the homeless population, they tended to generalize the characteristics of that subgroup to the whole. Reasons given for homelessness varied among regions of the state. Economic factors, such as unemployment and lack of low-cost housing, were cited in some regions but not others. Family problems, drug, alcohol, and mental health problems and deinstitutionalization were cited by some. When asked what percentage of homeless people in their areas experienced such things as physical, psychological or alcohol problems, Key Informants' responses often ranged from zero percent to 100 percent. Most saw shelter, housing, food, money and a variety of services as the major needs of homeless people.

In some regions of the state, Key Informants' descriptions of the causes of homelessness and the problems experienced by homeless people were consistent with the services they indicated were needed. In some regions, they were not. For some regions, there were also inconsistencies between what the Key Informants told us about the characteristics and problems of the homeless populations in their areas and what we found in the research. It seems clear that Key Informants and the broad human service systems in local communities could benefit from more specific information about homeless people in their areas in order to better address the problems of this population.

HOMELESS PERSON SURVEY -- STATEWIDE RESULTS

This section of the report deals with the results of face-to-face interviews with 979 homeless people. All interviewees did not answer every question. In some instances this was because the question was not asked, e.g. if the individual responded that he had always lived in his county, he was not asked the follow-up question "Where did you live before you came to this county?" Each table has a total at the bottom of the "Number" column of individuals eligible to answer that question, on which percentages of that item were calculated. In those instances, a column labeled "% of Total" is also provided, to indicate what percentage the individual line item represents of the total homeless group. In a few instances, interviewees did not know the answer or did not choose to answer particular questions. These are indicated as "No answer" in the last line of each table.

Interviews Completed

During a six-month period ending in August, 1984, a total of 979 face-to-face interviews was completed. Table S1 shows the number of interviews completed per region and per county within each region.

Of the five regions, four reached, or came very near reaching, their assigned regional quota of interviews. As was indicated earlier, this was accomplished in part through reallocation of unused rural interviews to the region's major urban center. Since the Southeast Region does not contain a major urban center, its unused rural interview quota was assigned to an urban area outside the region.

The very small number, or total lack, of interviews completed in some of the rural counties may be explained by a combination of factors. First, the quota of 25 interviews in rural/mixed counties was set artificially high in order to provide sufficient cases to be analyzed statistically. Second, according to key informants and actual "scouting" by field interviewers, there are probably some rural counties in which there are genuinely very few homeless people. Some of these counties may be unique situations, e.g. Holmes County contains one of the largest Amish populations in the United States. Third, we did not use enough interviewers who were indigenous to the rural counties. They probably would have been more successful in securing interviews than "outsiders".

Table S1

Interviews Completed
(N = 979)

Region and County	Number	%
Northeast Region	376	38.4
Cuyahoga	286	29.2
Ashland	13	1.3
Geauga	0	0.0
Holmes	0	0.0
Mahoning	77	7.9
Northwest Region	151	15.4
Lucas	133	13.6
Wood	11	1.1
Paulding	2	0.2
Fulton	5	0.5
Central Region	151	15.4
Franklin	112	11.4
Union	13	1.3
Wyandot	18	1.8
Pickaway	8	0.8
Southeast Region	55	5.6
Jefferson	30	3.1
Washington	7	0.7
Noble	8	0.8
Hocking	10	1.0
Southwest Region	246	25.1
Hamilton	182	18.6
Clermont	29	3.0
Brown	11	1.1
Logan	24	2.5

Demographics

The group of homeless people interviewed was 81 percent male and 19 percent female. This distribution is quite different from that of the overall Ohio population, which was 47.2 percent male and 52.8 percent female as of the 1980 Census. Minorities accounted for one-third of the homeless population; in comparison, the Ohio population had 10.1 percent minorities in the 1980 Census.

Homeless interviewees spanned a wide age range--from 16 to 83 years old, with the average age being 37 and the median age being 34. (Note: Interviewers only approached those persons they thought were at least 18 years old. However, four individuals turned out to be below that age. They were retained as part of the sample.) In some age groups, such as 40 to 49 and 50 to 59, the homeless population is proportionally similar to the overall Ohio population. However, the 30 to 39 age group and the group over 60 differ in their proportions from Ohio as a whole. (Note: The Ohio population percentages in Table S2 were calculated using only individuals 18 years of age or older, in order to show the appropriate proportional comparisons with the homeless sample, since the homeless sample was selected to be 18 years of age or older.)

A little over half (54.4%) of the homeless group had not graduated from high school, compared to 36.1 percent in the overall Ohio population. However, 44.9 percent of the homeless group were at least high school graduates, and 14.5 percent had attended or had graduated from college. (Note: The Ohio census data on education is computed on a base of persons 25 years old and over, so the comparison presented in Table S2 is of slightly different age groups.

Nearly half of the homeless respondents have never been married, and another 43.4 percent are either separated, widowed or divorced. These figures contrast dramatically with the overall Ohio population, in which 58.8 percent are married, and only 16 percent are separated, widowed or divorced. (Note: the Ohio census data on marital status is computed on a base of persons 15 years old and over, and those are the percentages reported in Table S2. The Census has only a category of "single", whereas our study had "never been married" and "living together".)

Almost 32 percent of the homeless sample indicated that they were veterans, including 8.5 percent who said they were Vietnam veterans. In the overall Ohio population aged 16 years and over, 17.3 percent are veterans. However, some of the contrast in percentages between the two groups is a function of the fact that the homeless sample is 81 percent male, and males have a higher likelihood of having served in the military.

Respondents were asked if they had ever been in jail or prison. Fifty-eight percent indicated that they had, and 40.7 percent said they had not. No Census data for the overall Ohio population are available for comparison.

Table S2

Demographics of the Homeless Sample, Compared to Ohio Population

CHARACTERISTIC	Homeless Sample		Ohio %
	Number	% of Total	1980 Census
SEX			
Male	793	81.0	47.2
Female	186	19.0	52.8
Total	979	100.0	100.0
ETHNICITY			
White	639	65.3	89.8
Black	292	29.8	9.2
Hispanic	33	3.4	0.9
Other	6	0.6	0.1
No answer	9	0.9	----
Total	979	100.0	100.0
AGE			
18 - 29 years	340	34.7	30.0
30 - 39 years	270	27.6	18.9
40 - 49 years	164	16.8	14.2
50 - 59 years	130	13.3	15.2
60 years and over	63	6.4	21.7
No answer	12	1.2	----
Total	979	100.0	100.0
EDUCATION			
No formal schooling	8	0.8	0.5
1 - 8 grades	161	16.4	13.3
9 - 11 grades	364	37.2	22.3
High school graduate	298	30.4	39.2
Some college	119	12.2	13.4
College graduate	22	2.3	11.3
No answer	7	0.7	----
Total	979	100.0	100.0
MARITAL STATUS			
Married	88	9.0	58.8
Separated	135	13.8	1.4
Widowed	43	4.4	7.7
Divorced	247	25.2	6.9
Never been married	438	44.7	25.2
Living together	21	2.1	----
No answer	7	0.7	----
Total	979	99.9	100.0
VETERAN STATUS			
Yes	310	31.7	17.3
(Vietnam Veteran)	(83)	(8.5)	(4.4)
No	665	67.9	82.7
No answer	4	0.4	----
Total	979	100.0	100.0
EVER BEEN IN JAIL/PRISON			
Yes	573	58.5	----
No	398	40.7	----
No answer	8	0.8	----
Total	979	100.0	----

Homelessness

For most of the individuals interviewed, homelessness was a relatively new phenomenon. Nearly 75 percent of all respondents reported being homeless for one year or less; the median was sixty days. However, because of the extreme scores of some of the respondents (5 percent were homeless longer than eight years, including nine people who had been homeless for over 30 years), the mean number of days homeless is 617.6. Table S3 presents statistics concerning the length of time respondents had been homeless.

Table S3

Length of Time Respondents Had Been Homeless

TIME	Number	% of Total
30 days or less	381	38.9
31 - 60 days	96	9.8
61 - 365 days	238	24.3
366 - 730 days	67	6.8
731 days or more	147	15.0
No answer	50	5.1
Total	979	99.9
Mean number of days	617.6	
Median number of days	60	

As discussed in an earlier section of this report, the sampling plan in urban areas was to try to interview equal numbers of homeless people based on four levels of living condition -- limited or no shelter; missions and shelters for homeless people; cheap hotels and motels; and other unique living arrangements. In rural areas, interviewers were to interview all homeless people regardless of their living situation. The results of this effort were that 288 respondents (29.4%) reported having spent the previous night in limited or no shelter; 32.1 percent had slept in missions or shelters for homeless people; 17.5 percent stayed in cheap hotels or motels; and 20.8 percent spent the previous night in "other" situations such as with family, friends or in unique living conditions such as jail, emergency rooms, or tents. Staying with family and friends accounted for over three-fourths of the "other" category. Table S4 presents data on where respondents slept the night previous to being interviewed.

Table S4

Place Respondents Slept Last

PLACE	Number	% of Total
Limited or no shelter	288	29.4
(No shelter)	(161)	(16.4)
(Car, abandoned building, public facility)	(127)	(13.0)
Mission, shelter	314	32.1
Cheap motels and hotels	171	17.5
Other	204	20.8
(With family)	(60)	(6.1)
(With friends)	(102)	(10.4)
(Unique conditions)	(42)	(4.3)
No answer	2	0.2
Total	979	100.0

Respondents gave many reasons, often interrelated, for their homelessness. When asked to specify the one major reason, economic factors (unemployment, problems paying rent, eviction, and government benefits stopped) were cited by half of the sample. These factors parallel those cited by Cuomo (1982) and Bassuk (1984) as being three of the four major reasons for the growing number of homeless people today, i.e. unemployment, lack of low cost housing and recent cuts in government benefits.

Family problems (family conflict and family dissolution) were cited by 21.3 percent of the respondents as the major reason for their homelessness. The idea of homeless people as "happy hobos" is not borne out by the data, as only 6.1 percent gave the major reason why they are homeless as "just like to move around". Table S5 shows the reasons for homelessness as reported by the homeless respondents.

Table S5

Reported Major Reason for Homelessness

REASON	Number	% of Total
Unemployment	213	21.7
Problems paying rent	136	13.9
Family conflict	130	13.3
Eviction	94	9.6
Other reasons	92	9.4
Family dissolution	78	8.0
Alcohol/drug abuse	71	7.3
Just like to move around	60	6.1
Government benefits stopped	27	2.8
Disaster	24	2.5
Deinstitutionalization	24	2.5
Was in jail/prison	16	1.6
No answer	14	1.4
Total	979	100.1

Transience

In general, the homeless people interviewed do not appear highly mobile. Slightly less than sixty percent said they had stayed in two or fewer different places during the past month, with slightly less than 85 percent staying in four or fewer different places during the past month. Table S6 provides figures on number of places stayed.

Table S6

Number of Places Stayed During Past Month

NUMBER	Number	% of Total
1 - 2 places	559	57.1
3 - 4 places	245	25.0
5 - 6 places	69	7.0
7 - 8 places	20	2.0
More than 8 places	57	5.8
No answer	29	3.0
Total	979	99.9
Mean number of places	3.3	
Median number of places	2	

Results indicate that 63.5 percent of respondents are either long-term (more than one year) or permanent residents of the area where they were interviewed. Thirty-one percent of the respondents were fairly recent arrivals in their counties, having been there six months or less. Table S7 gives statistics on the length of time the respondents have been in the county where they were interviewed.

Table S7

Length of Time in County

TIME	Number	% of Total
Less than one week	98	10.0
1 - 4 weeks	126	12.9
1 - 6 months	81	8.3
7 - 12 months	45	4.6
More than one year	234	23.9
Permanent resident	388	39.6
No answer	7	0.7
Total	979	100.0

For those respondents who were not permanent residents of the county where they were interviewed, about one-third came from other Ohio counties, about one-third from the five states that are contiguous to Ohio, and the remainder from other states or countries. See Table S8 for exact figures on where the homeless respondents lived prior to coming to their current county of residence.

Table S8

Where Non-Permanent-Resident Respondents Lived Prior to Coming to this County

WHERE	Number	% of Item	% of Total
Another Ohio county	205	34.7	20.9
Pennsylvania	34	5.8	3.4
West Virginia	27	4.6	2.8
Kentucky	39	6.6	4.0
Indiana	16	2.7	1.6
Michigan	36	6.1	3.7
Other states	211	35.7	21.6
Other countries	4	0.7	0.4
No answer	19	3.2	1.9
Total	591	100.1	60.3

Analysis of the data shows a variety of reasons why non-permanent residents came to the county where they were interviewed. Slightly more than 25 percent came seeking assistance from family and friends, and 27.8 percent came to either look for a job or take a job. Only 9 percent came seeking public social support such as shelter accommodations or social services.

The 10 percent who were "just passing through" probably include the 6.1 percent who said that the major reason for their homelessness is that they "just like to move around." Table S9 lists the major reasons why the respondents came to the county where they were interviewed.

Table S9

Reason for Non-Permanent Residents Coming to County

REASON	Number	% of Item	% of Total
To live with relative or friend	149	25.2	15.2
To look for a job	112	19.0	11.4
Other reasons	87	14.7	8.9
Just another stop while passing through	61	10.3	6.2
To take a job	52	8.8	5.3
For public sleeping shelters	33	5.6	3.5
Lived here before	34	5.8	3.5
For social service programs	9	1.5	0.9
To go to school	9	1.5	0.9
Heard you could get on welfare	6	1.0	0.6
For community kitchens	4	0.7	0.4
Less police hassle	2	0.3	0.2
No answer	33	5.6	3.3
Total	591	100.0	60.3

Employment and Income

In response to questions about their work history, 855 (87.3%) homeless respondents indicated that they had had a job at some point in their life, including 242 (24.7%) people who said they had worked for pay in the past month. Table S10 shows the types of work those individuals did during the past month.

Table S10

Type of Work Done by Those Who Had Worked
in the Past Month

TYPE	Number	% of Item	% of Total
Day labor	84	34.7	8.6
Permanent, full-time	60	24.8	6.1
Temporary job	59	24.4	6.0
Permanent, part-time	24	9.9	2.5
Other	13	5.3	1.3
No answer	2	0.8	0.2
Total	242	99.9	24.7

Individuals who had worked in the past but who were not now employed were asked in what year they last worked. Over one-third reported having last worked in the past 18 months, and about another one-third said they last worked between 1978 and 1982. See Table S11.

Table S11

Year Last Worked for Those Who Have Not Worked During the Past Month

YEAR	Number	% of Item	% of Total
1983 - 1984	229	37.4	23.4
1978 - 1982	227	37.0	23.2
1969 - 1977	87	14.2	8.9
Prior to 1969	31	5.1	3.2
No answer	39	6.3	4.0
Total	613	100.0	62.7

Individuals who had worked in the past but who were not now employed were asked why their last job ended. Most frequently cited reasons were that they quit or were fired, the job was only a temporary one, they were laid off, or the company closed or moved. Table S12 presents information on reasons last jobs ended.

Table S12

Reason of Formerly Employed Respondents for Last Job Ending

REASON	Number	% of Item	% of Total
Quit	106	17.3	10.8
Temporary job	100	16.3	10.2
Fired	93	15.2	9.5
Company closed/moved	62	10.1	6.3
Laid off	60	9.8	6.1
Other reasons	59	9.6	6.0
Poor physical health	57	9.3	5.8
Drinking/drugs	33	5.4	3.4
Poor mental health	19	3.1	1.9
Went to prison/jail	10	1.6	1.0
CETA benefits ended	2	0.3	0.2
No answer	12	2.0	1.2
Total	613	100.0	62.4

The two most frequently cited reasons (by 67.8% of the respondents) for not working now were: they have looked, but cannot find a job, or they are disabled and cannot work. Table S13 shows the major reasons why formerly-employed respondents are not working now.

Table S13

Reason of Formerly Employed Respondents for Not Working Now

REASON	Number	% of Item	% of Total
Looked, but cannot find work	289	47.1	29.5
Disabled/cannot work	127	20.7	13.0
Other reasons	56	9.1	5.7
Plan to look for work	34	5.5	3.5
Do not want to work	29	4.7	3.0
Do not feel ready to work	29	4.7	3.0
To stay home with children	19	3.1	1.9
Alcohol/drug problem	9	1.5	0.9
Do not know where to look for work	8	1.3	0.8
Do not want to lose benefits	4	0.7	0.4
Do not need to work	3	0.5	0.3
Poor education	3	0.5	0.3
No answer	3	0.5	0.3
Total	613	99.9	62.6

In all, 622 (63.4%) homeless respondents indicated that they have had some income during the past month. Welfare, earnings or Social Security were the primary sources of income for over 80 percent of those respondents. Table S14 lists the primary sources for respondents' income.

Table S14

Primary Income Source for Respondents Who Had Income in the Past Month

SOURCE	Number	% of Item	% of Total
Welfare	233	37.5	23.8
Earnings	167	26.8	17.1
Social Security	124	19.9	12.7
Other sources	21	3.4	2.1
Family/friends	19	3.1	1.9
Refused to disclose	14	2.3	1.4
Pension	13	2.1	1.3
Charity	11	1.8	1.1
Mission/shelter work	9	1.4	0.9
Giving blood	9	1.4	0.9
No answer	2	0.3	0.2
Total	622	100.0	63.4

Social Service Usage

Respondents were asked whether or not they had used specific kinds of social services within the past month. Of the six social services listed in the questionnaire, community kitchens was the one most used by homeless respondents (60.8%). Shelters were the second most used service (56.4%), followed by welfare/general relief (44.4%). For the women, only 12.4 percent had ever used a shelter for battered women. Table S15 gives the numbers and percentages of respondents who said they had used each particular social service.

Table S15

Social Service Usage

SOCIAL SERVICE	Total	Number	% of Total
Community kitchens	979	595	60.8
Shelters	979	552	56.4
Welfare/general relief	979	435	44.4
Hospital emergency rooms	979	240	24.5
Shelters for battered women	186	23	12.4
Community mental health centers	979	119	12.2

Community kitchens were also found to be the primary source of food for the largest number of homeless people (43.4%). Some individuals indicated that they were able to buy food at a store and prepare their own meals, while others said they primarily relied on handouts. Almost none of the homeless people interviewed used dumpsters or stealing as a major means to obtain food. Table S16 presents statistics on where homeless people generally got their meals.

Table S16

Primary Source of Meals

PRIMARY FOOD SOURCE	Number	% of Total
Community kitchen	425	43.4
Buy at store; cook one's own	163	16.6
Handouts	117	12.0
Restaurant	68	6.9
Family and friends	49	5.0
Other sources	46	4.7
Mission/shelters	34	3.5
Food pantry; cook one's own	27	2.8
Do without	27	2.8
Dumpsters; trash	15	1.5
Vending machines	2	0.2
Stealing	2	0.2
No answer	4	0.4
Total	979	100.0

Psychiatric Hospitalization

A total of 293 respondents (29.9%) has been hospitalized at least once for emotional or mental health problems. One hundred eighty individuals, 18.4 percent of the total sample, have been hospitalized at least once in a state psychiatric hospital. Table S17 presents the results of respondents' psychiatric hospitalization in veterans, general/private and state hospitals.

Table S17

Psychiatric Hospitalization

HOSPITALIZATION	Number	% of Total
Never been hospitalized	673	68.7
Been hospitalized	293	29.9
(Veteran's hospital)	(60)	(6.1)*
(General hospital)	(129)	(13.2)*
(State hospital)	(180)	(18.4)*
No answer	13	1.3
Total	979	99.9

* Hospitalized subtotals do not add to 29.9% because some respondents have had hospitalizations in more than one type of setting.

Of those 180 persons who had been hospitalized in a state psychiatric hospital, 38.9 percent were hospitalized once, and the median number of hospitalizations was two. However, 11.7 percent said they had been hospitalized seven or more times. See Table S18 for figures on the hospitalization history of those respondents who were ever hospitalized in a state psychiatric hospital.

Table S18

Number of Times Hospitalized for Those Ever Hospitalized in a State Psychiatric Facility

TIMES HOSPITALIZED	Number	% of Item	% of Total
one	70	38.9	7.2
two	29	16.1	3.0
3 - 4	27	15.0	2.8
5 - 6	18	10.0	1.8
7 or more	21	11.7	2.1
No answer	15	8.3	1.5
Total	180	100.0	18.4
Mean number of times hospitalized		3.7	
Median number of times hospitalized		2	

Of the 180 homeless individuals (18.4%) who have ever been in a state psychiatric hospital, 45.5 percent were last released in 1983 or 1984. Nearly one-fourth (23.9%) were last released in 1978 or earlier. Table S19 presents statistics on the years in which those respondents were last released from state hospitals.

Table S19

Year Last Released for Those Ever Hospitalized in a State Psychiatric Hospital

YEAR	Number	% of Item	% of Total
1984 - 1983	82	45.5	8.4
1982 - 1981	23	12.8	2.3
1980 - 1979	14	7.8	1.4
1978 - 1970	29	16.1	3.0
1969 or before	14	7.8	1.4
No answer	18	10.0	1.8
Total	180	100.0	18.4

Upon their last release from the state hospital, 60 percent said that the hospital arranged some sort of community living situation for them. Thirty-five percent said that no living arrangements were made for them. Of those 108 respondents who said arrangements were made for them (i.e., were released to family, own apartment, hotel, etc.), 95 (88.0%) said that they went to that arranged place to live. Table S20 presents data on reported living arrangements for those who were released from a state hospital.

Table S20

Reported Living Arrangements for Respondents Released From State Hospitalization

RELEASED TO	Number	% of Item	% of Total
No arrangements were made	63	35.0	6.4
Family	42	23.3	4.3
Other arrangements	21	11.7	2.1
Own apartment or house	20	11.1	2.0
Group home	18	10.0	1.8
Hotel/motel	7	3.9	0.7
No answer	9	5.0	0.9
Total	180	100.0	18.2
Arrangements were made (N=108)			
Went to the place arranged for them (N=95)	95	88.0	9.7

When asked if staff at the state hospital talked to them about going to a community mental health center, 100 respondents (55.6%) said yes. Of those 100, 68 did, in fact, have contact with a community mental health center after their release from the state hospital. In most cases, respondents indicated that they had initiated the contact with the mental health center, rather than the center contacting them. Table S21 gives information about respondents' reported contact with a community mental health center.

Table S21

Contact with a Community Mental Health Center
for Those Referred

TYPE OF CONTACT	Number	% of Item	% of Total
I contacted them	56	56.0	5.7
They contacted me	12	12.0	1.2
No contact	29	29.0	3.0
No answer	3	3.0	0.3
Total	100	100.0	10.2

When asked how they would feel about returning to a state hospital if they were having emotional problems again, a little over 50 percent said they would not want to return, but 40.5 percent said they would either like to or would not mind going back in that situation. Table S22 outlines respondents' feelings about returning to a state hospital.

Table S22

Feelings about Returning to a State Hospital
by Those Ever Hospitalized

FEELINGS	Number	% of Item	% of Total
Not want to go back	95	52.8	9.7
Not mind going back	51	28.3	5.2
Like to go back	22	12.2	2.2
Not thought about it	7	3.9	0.7
Would go back for shelter	1	0.6	0.1
No answer	4	2.2	0.4
Total	180	100.0	18.3

Social Network

When respondents in this study were asked if they had any relatives they could count on for help, 36 percent said yes, 42.8 percent said no, and 20 percent said they had no relatives.

This same question was asked of a random sample of the general adult population in five rural Ohio counties (Stefl, 1983). In that sample, 92.4 percent said that they had relatives they could count on for help, 4.4 percent said they could not count on relatives they had, and 3.2 percent said they had no relatives. These results seem to indicate that homeless persons see themselves as more cut off from family and less likely to be able to count on the relatives they do have than do individuals in the general population. See Table S23.

Table S23

"Do you have any relatives you can count on for help?"

RESPONSE	HOMELESS STUDY Number	 % of Total	STEFL/OHIO % (N=2157)
Yes	352	36.0	92.4
No, can't count on	419	42.8	4.4
No, no relatives	196	20.0	3.2
No answer	12	1.2	—
Total	979	100.0	100.0

For those study respondents who said they have relatives, 50 percent have had contact with their relatives within the past 14 days, and 75 percent have had contact within the past ninety days. Table S24 presents these data.

Table S24

Time Since Contact with Relatives
for Those Who Have Relatives

DAYS	Number	% of Item	% of Total
1 - 7	327	42.4	33.4
8 - 30	144	18.7	14.7
31 - 90	87	11.3	8.9
91 - 180	42	5.4	4.3
181 - 365	46	6.0	4.7
366 or more	93	12.1	9.5
No answer	32	4.1	3.3
Total	771	100.0	78.8
Mean number of days	284.5		
Median number of days	14		

If respondents said it had been longer than a month since they had had contact with their relatives, they were asked the major reason why they did not have contact more often. Most frequently cited reasons were: no desire on their part to maintain the relationship (23.1%); the relatives did not want to see them (20.5%), and the relatives do not live nearby (20.5%). See Table S25.

Table S25

Reasons for Infrequent Contact with Relatives for Those Who Have Not Had Contact for More Than One Month

REASONS	Number	% of Item	% of Total
No desire to maintain relationship	62	23.1	6.3
Relatives do not want to see me	55	20.5	5.6
Relatives do not live nearby	55	20.5	5.6
They would not help	34	12.7	3.5
Other reasons	20	7.5	2.0
I'm ashamed of current situation	12	4.5	1.2
It has been too long since I've seen them	10	3.7	1.0
Do not know where they are	4	1.5	0.4
They cannot help me/they need help too	3	1.1	0.3
No transportation	1	0.4	0.1
No answer	12	4.5	1.2
Total	268	100.0	27.2

When respondents were asked if they have friends they can count on for help, 41 percent said yes, 31.4 percent said no, and 26.8 percent said they had no friends. For those who said they had friends, 54 percent said they thought they had enough close friends.

These same two questions were asked of the random sample of the general population (as mentioned earlier) in five rural Ohio counties. In that sample, 94.9 percent said they had close friends they could count on, 4.7 percent said they had no close friends they could count on, and .4 percent said they had no friends. In addition, 82.3 percent said they had enough close friends. As was the case with relatives, homeless people clearly see themselves as being more isolated in terms of friends than the general population and less likely to be able to count on friends that they do have. See Tables S26 and S27.

Table S26

"Do you have any friends you can count on for help?"

RESPONSE	HOMELESS STUDY		STEFL/OHIO %	
	Number	% of Total	Response	(N=2157)
Yes	401	41.0	Yes	94.9
No, can't count on	307	31.4	No	4.7
No, no friends	262	26.8	Uncertain	0.4
No answer	9	0.9		----
Total	979	100.1		100.0

Table S27

"Do you have enough close friends?"

RESPONSE	HOMELESS STUDY			STEFL/OHIO %
	Number	% of Item	% of Total	(N=2141)
Yes	382	54.9	39.0	82.3
No	315	44.5	32.2	17.7
No answer	11	1.6	1.1	----
Total	708	100.0	72.3	100.0

The results indicate that for those homeless respondents who have friends, contacts with those friends are frequent. Over 70 percent have had contact with friends in the last week, and 50 percent within the last day. See Table S28.

Table S28

Time Since Last Contact with Friends
for Those Who Have Friends

DAYS	Number	% of Item	% of Total
1 - 7	502	70.9	51.3
8 - 30	68	9.6	6.9
31 - 90	31	4.4	3.2
91 - 180	17	2.4	1.7
181 - 365	19	2.7	1.9
366 or more	23	3.2	2.3
No answer	48	6.8	4.9
Total	708	100.0	72.2
Mean number of days	80.5		
Median number of days	1		

Those respondents who had not had contact with their friends for more than thirty days were asked the major reason why the contact was so infrequent. Reasons most frequently cited were that their friends do not live nearby, the respondents have no desire to maintain the relationship, or they feel that their friends would not help.

Physical Health Problems

Many studies have reported the high incidence of physical and drug/alcohol problems of homeless people. In Bassuk's Boston shelter study (1984), she estimated 29 percent of the residents to be chronic alcoholics, and about 45 percent of her study group reported serious physical problems, including heart disease and cancer.

Respondents in our study were also asked questions about any physical problems they have, their use of drugs and medication, and about their drinking behavior. Results seem to indicate a lower level of health problems in our homeless population than in the Bassuk study. When asked if they currently had a physical problem they thought they should see a doctor about, slightly less than one-third said yes.

The category of physical problems most mentioned by the respondents was conditions of an ill-defined nature such as headaches, queasiness in the stomach or pains somewhere in the body. Other physical problems that were mentioned by quite a few respondents were arthritis and other problems of the musculoskelatal system, heart and circulation problems, and injury and poisoning. Table S29 presents statistics on the kinds of physical problems homeless people reported having.

Table S29

Physical Health Problems

PROBLEM	Number	% of Total
Reported no physical problems	669	68.3
Reported physical problems	301	30.7
Ill-defined conditions	(89)	(9.1)
Arthritis, rheumatism and other diseases of the musculoskeletal system	(49)	(5.0)
Injury and Poisoning	(42)	(4.3)
Diseases of the heart and circulatory system	(38)	(3.9)
Diseases of the nervous system and sense organs	(34)	(3.5)
Diseases of the respiratory system	(30)	(3.1)
Diseases of the digestive system	(28)	(2.9)
Eye Problems	(22)	(2.2)
Endocrine and nutritional disorders	(18)	(1.8)
Dental Problems	(16)	(1.6)
Infections and parasitic disorders	(11)	(1.1)
Neoplasms (cancer and benign tumors)	(10)	(1.0)
Diseases of the genito-urinary system	(10)	(1.0)
Pregnancy	(9)	(0.9)
Diseases of the blood	(8)	(0.8)
Alcoholism	(6)	(0.6)
Diseases of the skin	(4)	(0.4)
No answer	(4)	(0.4)
No answer	9	0.9
Total	979	99.9

Note: Subtotals for types of problems do not add to 30.7 because 127 respondents indicated they had two problems.

Respondents were asked if they had taken any drugs or medications within the past month and, if so, whether these had been prescribed by a doctor. Two-thirds of the homeless respondents indicated that they had not used any drugs or medications. Of those who said they did, almost three-quarters indicated that the drugs were prescribed for them by a doctor. When asked if they had had any trouble with the use of any drug in the past month, only 47 individuals (14.9%) said yes. Table S30 shows usage of drugs and medications among the study group as well as whether the drugs were prescribed and whether they caused problems.

Table S30

Usage of Drugs and Medications Within the Past Month

USAGE CATEGORY	Number	% of Item	% of Total
Use drugs or medications (N=979)			
Yes	315	----	32.2
No	658	----	67.2
No answer	6	----	0.6
Total	979	----	100.0
If used drugs/medications (N=315)			
A. Drugs/medications are prescribed			
Yes	221	70.2	22.6
No	77	24.4	7.9
Some were; some weren't	15	4.8	1.5
No answer	2	0.6	0.2
Total	315	100.0	32.2
B. Trouble with drugs/medications			
Yes	47	14.9	4.8
No	250	79.4	25.5
No answer	18	5.7	1.8
Total	315	100.0	32.1

Respondents were asked about their drinking behavior during the past month. Nineteen percent said they had been drinking a lot, however 35.2 percent said they had not been drinking at all during the past month. Table S31 shows drinking behavior as reported by all homeless respondents.

Table S31

Reported Drinking During the Past Month

AMOUNT OF DRINKING	Number	% of Total
Some	441	45.0
A lot	188	19.2
Not at all	345	35.2
No answer	5	0.5
Total	979	99.9

Regardless of their response concerning how much they had been drinking the past month, all individuals in the study were asked whether they had ever gone to anyone for help about their drinking. A little over one-fourth said that they had, as indicated by Table S32.

Table S32

Seeking Help for Drinking

BEHAVIOR	Number	% of Total
Have ever sought help	260	26.6
Have not sought help	693	70.8
No answer	26	2.7
Total	979	100.1

General Well-being

In order to measure homeless people's sense of their own mental health status, interviewees were asked two general well-being items drawn from the Florida Health Study (Schwab, J., et al, 1979), a large-scale study of psychiatric epidemiology conducted in the early 1970's. The questions have been used widely for mental health needs assessment purposes, including some studies done in Ohio.

When homeless respondents were asked to rate their nerves, spirits, outlook or mental health at present, over 40 percent responded with "good" or "excellent", and only 7.9 percent said "very bad". These results would seem to indicate that a surprisingly large percentage of homeless people are in good spirits despite their circumstances.

Comparative data on these same two items are available from two random probability samples of 2,183 people in five rural southern Ohio counties (Stefl, 1983). These data seem to indicate that the general population rates its spirits and outlook as being substantially higher than the homeless population, as Table S33 shows.

Table S33

"How would you rate your nerves, spirits, outlook, or mental health at present?"

RESPONSE	HOMELESS		STEFL/OHIO %
	Number	% of Total	(N=2183)
Excellent	90	9.2	33.0
Good	305	31.2	52.4
Fair	338	34.5	12.6
Poor	152	15.5	1.3
Very bad	77	7.9	0.6
No answer	17	1.7	----
Total	979	100.0	100.0

Respondents were also asked how satisfying their life had been. One-third indicated that it had been very satisfying or somewhat satisfying, but 28.1 percent rated it as not very or not at all satisfying. In this instance, comparisons with the Ohio sample are even more dramatic, since 86.5 percent of the latter group said they considered their lives to have been very satisfying or somewhat satisfying, as shown in Table S34.

Table S34

"In general, how satisfying would you say your life has been?"

RESPONSE	HOMELESS Number	HOMELESS % of Total	STEFL/OHIO % (N=2183)
Very satisfying	96	9.8	58.3
Somewhat satisfying	232	23.7	28.2
Mixed	360	36.8	11.1
Not very satisfying	196	20.0	1.9
Not at all satisfying	79	8.1	0.6
No answer	16	1.6	----
Total	979	100.0	100.0

URBAN/NON-URBAN COUNTY COMPARISONS

Data were initially analyzed in terms of the three county types: urban, mixed and rural. However, in most cases the analysis proved to be most meaningful when the urban counties were compared to non-urban counties (i.e., combining the mixed and rural counties into one entity). In cases when significant differences really appeared to exist between the three different county types, these are discussed.

Interviews Completed

A total of 790 (80.7%) urban interviews and 189 (19.2%) non-urban interviews were completed. See Table U1.

Table U1

Interviews Completed
(N=979)

COUNTIES	Number	% of Item	% of Total
Urban			
Cuyahoga	286	36.2	29.2
Mahoning	77	9.7	7.9
Lucas	133	16.8	13.6
Franklin	112	14.2	11.4
Hamilton	182	23.0	18.6
Total	790	99.9	80.7
Non-Urban			
Ashland (M)	13	6.9	1.3
Geauga (R)	0	0.0	0.0
Holmes (R)	0	0.0	0.0
Wood (M)	11	5.8	1.1
Paulding (R)	2	1.0	0.2
Fulton (R)	5	2.6	0.5
Union (M)	13	6.9	1.3
Wyandot (R)	18	9.5	1.8
Pickaway (R)	8	4.2	0.8
Jefferson (M)	30	15.9	3.1
Washington (M)	7	3.7	0.7
Noble (R)	8	4.2	0.8
Hocking (R)	10	5.3	1.0
Clermont (M)	29	15.3	3.0
Brown (R)	11	5.8	1.1
Logan (R)	24	12.8	2.5
Total	189	99.9	19.2

R=Rural County M=Mixed County

Demographics

Homeless persons in the urban counties differ demographically from homeless persons in the non-urban counties. In terms of age, 31.6 percent of homeless persons in urban counties were 29 years old or less, while 38.9 percent were 40 years or older. Homeless persons in non-urban counties tended to be younger: 47.6 percent were 29 years old or less, while only 26.4 percent were 40 years or older. In the urban counties, homeless persons were more likely to be male than in the non-urban counties (84.2% vs. 67.7%).

Not surprisingly, given the demographic profile of the different types of counties, homeless persons in the rural and mixed counties were almost all white (91.5%). In the urban counties, 59 percent of the homeless persons were white, 35.6 percent black, 3.8 percent hispanic, and 0.8 percent identified with other racial groups.

Relatively few urban homeless people were currently married or living with a partner (8.2%). Almost half (46.3%) had never been married; 25.2 percent were divorced, and 19.3 percent were separated or widowed. In the non-urban counties, 23.3 percent were currently married or living together; 38.1 percent had never been married, 25.4 percent had been divorced, and 13.2 percent were separated or widowed.

There were no significant differences among the urban and non-urban counties in terms of the educational attainment of homeless persons.

Homeless persons in the urban counties were slightly more likely to have served in the military--33.4 percent versus 24.3 percent in the non-urban counties.

Only slight differences were observed in the incidence of incarceration for urban (59.5%) and non-urban (54.5%) homeless people. Although not obtainable in this data set, it is possible that many of these experiences involved short stays for charges such as vagrancy. See Table U2 for demographic comparisons of urban and non-urban counties.

Table U2

Demographic Comparisons of Urban and Non-Urban Counties

CHARACTERISTIC	URBAN Number	URBAN %	NON-URBAN Number	NON-URBAN %	TOTAL Number	TOTAL %
SEX						
Male	665	84.2	128	67.7	793	81.0
Female	125	15.8	61	32.3	186	19.0
Total	790	100.0	189	100.0	979	100.0
ETHNICITY						
White	466	59.0	173	91.5	639	65.3
Black	281	35.6	11	5.8	292	29.8
Hispanic	30	3.8	3	1.6	33	3.4
Other	6	0.8	0	0.0	6	0.6
No answer	7	0.9	2	1.0	9	0.9
Total	790	100.1	189	99.9	979	100.0
AGE						
18 - 29 years	250	31.6	90	47.6	340	34.7
30 - 39 years	224	28.4	46	24.3	270	27.6
40 - 49 years	139	17.6	25	13.2	164	16.8
50 - 59 years	115	14.6	15	7.9	130	13.3
60 years and over	53	6.7	10	5.3	63	6.4
No answer	9	1.1	3	1.6	12	1.2
Total	790	100.0	189	99.9	979	100.0
EDUCATION						
No formal schooling	7	0.9	1	0.5	8	0.8
1 - 8 grades	129	16.3	32	16.9	161	16.4
9 - 11 grades	291	36.8	73	38.6	364	37.2
High school graduate	241	30.5	57	30.2	298	30.4
Some college	97	12.3	22	11.6	119	12.2
College graduate	19	2.4	3	1.6	22	2.3
No answer	6	0.8	1	0.5	7	0.7
Total	790	100.0	189	99.9	979	100.0
MARITAL STATUS						
Married	53	6.7	35	18.5	88	9.0
Separated	114	14.4	21	11.1	135	13.8
Widowed	39	4.9	4	2.1	43	4.4
Divorced	199	25.2	48	25.4	247	25.2
Never been married	366	46.3	72	38.1	438	44.7
Living together	12	1.5	9	4.8	21	2.1
No answer	7	0.9	0	0.0	7	0.7
Total	790	99.9	189	100.0	979	99.9
VETERAN STATUS						
Yes	264	33.4	46	24.3	310	31.7
(Vietnam Veteran)	(73)	(9.2)	(10)	(5.3)	(83)	(8.5)
No	523	66.2	142	75.1	665	67.9
No answer	3	0.4	1	0.5	4	0.4
Total	790	100.0	189	99.9	979	100.0
EVER BEEN IN JAIL/PRISON						
Yes	470	59.5	103	54.5	573	58.5
No	313	39.6	85	45.0	398	40.7
No answer	7	0.9	1	0.5	8	0.8
Total	790	100.0	189	100.0	979	100.0

* Table 2 notes:

1. Ohio Census data are available on slightly different age groups than the homeless sample, which was selected to be 18 years old or over. The differences are as follows:
   a. The Census distribution on education is based on persons 25 years of age and older
   b. The Census distribution on marital status is based on persons 15 years of age and older
   c. The Census distribution on veteran status is based on persons 16 years of age and older.
2. Census information about the percent of persons with no formal schooling is available for the state but not by county at this time. Therefore, this category is merged with "1-8 grades" in the county data.
3. Under marital status, the Census has only a category of "single", whereas our study had "never been married" and "living together".

Homelessness

Small differences were found between urban and non-urban respondents as to how long they had been homeless. Although 72.3 percent of urban respondents and 76.1 percent of non-urban respondents had been homeless for a year or less, there was a higher proportion of urban respondents who had been homeless more than two years. This latter group helped to generate a higher average number of days homeless for the urban respondents. See Table U3.

Table U3

Length of Time Respondents Had Been Homeless

TIME	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
30 days or less	308	39.0	73	38.6	381	38.9
31 - 60 days	71	9.0	25	13.2	96	9.8
61 - 365 days	192	24.3	46	24.3	238	24.3
366 - 730 days	50	6.3	17	9.0	67	6.8
731 days or more	126	16.0	21	11.1	147	15.0
No answer	43	5.4	7	3.7	50	5.1
Total	790	100.0	189	99.9	979	99.9
Mean number of days	675.9		378.4		617.6	
Median number of days	60.0		60.0		60.0	

In comparing where respondents had spent the previous night, no urban/non-urban county differences were observed in the usage of limited or no shelter or cheap motels and hotels. Differences were apparent in the use of missions/shelters and in staying with family and friends. Whereas 37.1 percent of urban homeless persons had spent the previous night in a mission or shelter, only 20.4 percent of the mixed county homeless respondents and none of the rural respondents had slept in a mission or shelter (for an average of 11.1 percent for the non-urban people). This may reflect the relative lack of mission or shelter facilities in non-urban areas as compared to cities. By contrast, non-urban people (40.7%) were much more likely to reside with friends or relatives than was the case for urban people (10.7%). This also may reflect the absence of institutional shelters for homeless people in non-urban areas. See Table U4.

Table U4

Place Respondents Slept Last

PLACE	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Limited or no shelter	238	30.1	50	26.5	288	29.4
(No shelter)	(131)	(16.6)	(30)	(15.9)	(161)	(16.4)
(Car, abandoned building, public facility)	(107)	(13.5)	(20)	(10.6)	(127)	(13.0)
Mission, shelter	293	37.1	21	11.1	314	32.1
Cheap motels and hotels	141	17.8	30	15.9	171	17.5
Other	116	14.7	88	46.6	204	20.8
(With family)	(28)	(3.5)	(32)	(16.9)	(60)	(6.1)
(With friends)	(57)	(7.2)	(45)	(23.8)	(102)	(10.4)
(Unique conditions)	(31)	(3.9)	(11)	(5.8)	(42)	(4.3)
No answer	2	0.2	0	0.0	2	0.2
Total	790	99.9	189	100.1	979	100.0

Although there are many reasons which might account for a person not having a home (e.g disaster, eviction, unemployment, etc.), proportions of people citing specific reasons did vary somewhat among urban and non-urban populations. While nearly half in both groups cited economic reasons as the primary cause of their homelessness, 28.6 percent of the non-urban group cited family problems (family conflict and family dissolution) as the major reason, compared to 19.5 percent of the urban group. See Table U5 for reasons why people indicated that they were homeless.

Table U5

Reported Major Reason for Homelessness

REASON	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Unemployment	173	21.9	40	21.2	213	21.7
Problems paying rent	111	14.1	25	13.2	136	13.9
Family conflict	100	12.7	30	15.9	130	13.3
Eviction	74	9.4	20	10.6	94	9.6
Other reasons	70	8.9	22	11.6	92	9.4
Family dissolution	54	6.8	24	12.7	78	8.0
Alcohol/drug abuse	63	8.0	8	4.2	71	7.3
Just like to move around	52	6.6	8	4.2	60	6.1
Government benefits stopped	27	3.4	0	0.0	27	2.8
Disaster	20	2.5	4	2.1	24	2.5
Deinstitutionalization	18	2.3	6	3.2	24	2.5
Was in jail/prison	15	1.9	1	0.5	16	1.6
No answer	13	1.6	1	0.5	14	1.4
Total	790	100.1	189	99.9	979	100.1

Transience

No differences were noted between urban and non-urban respondents when comparing the number of different places they had stayed during the past month. The mean number of places stayed for the urban respondents was 3.3, and for non-urban respondents was 3.1. The median number of places stayed at during the past month was two for both groups. See Table U6.

Table U6

Number of Places Stayed During Past Month

NUMBER	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
1 - 2 places	453	57.3	106	56.1	559	57.1
3 - 4 places	188	23.8	57	30.2	245	25.0
5 - 6 places	55	7.0	14	7.4	69	7.0
7 - 8 places	17	2.2	3	1.6	20	2.0
More than 8 places	50	6.3	7	3.7	57	5.8
No answer	27	3.4	2	1.1	29	3.0
Total	790	100.0	189	100.1	979	99.9
Mean number of places	3.3		3.1		3.3	
Median number of places	2.0		2.0		2.0	

Respondents in the urban counties were far more likely to report that they were born in the county in which the interview took place than respondents in non-urban counties (42.3% vs. 28.6%).

Among those 591 individuals not native to the interview county, there were only small county differences in the length of time they had been in the county. Just under a quarter of both urban and non-urban respondents resided in the county at least one year. This suggests that there exists a substantial number of homeless people in urban and non-urban environments who are not highly mobile, at least across county or state lines. See Table U7 for a description of respondents' length of stay in the county where interviewed.

Table U7

Length of Time in County

TIME	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Less than one week	76	9.6	22	11.6	98	10.0
1 - 4 weeks	101	12.8	25	13.2	126	12.9
1 - 6 months	58	7.3	23	12.2	81	8.3
7 - 12 months	30	3.8	15	7.9	45	4.6
More than one year	185	23.4	49	25.9	234	23.9
Permanent resident	334	42.3	54	28.6	388	39.6
No answer	6	0.7	1	0.5	7	0.7
Total	790	99.9	189	99.9	979	100.0

Our analysis attempted to identify the origin (residence) of homeless people who were not permanent residents of the area in which they were interviewed. This was accomplished by asking them where they came from before arriving in the county. Responses were collapsed into the following categories: any Ohio county, states adjacent to Ohio, all other states, and all other countries. Results showed that non-urban homeless people (49.6%) were much more likely to have originated from another Ohio county than urban (30.3%) homeless people. By contrast, urban homeless people (65.2%) were more likely to have come from another state, than was the case for non-urban homeless people (48.9%). This may suggest that urban homeless people are migrating to Ohio and remaining, while non-urban homeless people tend to both originate and remain here. See Table U8 for an explanation of where respondents came from.

Table U8

Where Non-Permanent Resident Respondents Lived
Prior to Coming to this County

WHERE	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Another Ohio county	138	30.3	67	49.6	205	34.7
Pennsylvania	25	5.5	9	6.7	34	5.8
West Virginia	20	4.4	7	5.2	27	4.6
Kentucky	34	7.5	5	3.7	39	6.6
Indiana	14	3.1	2	1.5	16	2.7
Michigan	31	6.8	5	3.7	36	6.1
Other states	173	37.9	38	28.1	211	35.7
Other countries	4	0.9	0	0.0	4	0.7
No answer	17	3.7	2	1.5	19	3.2
Total	456	100.1	135	100.0	591	100.1

Urban and non-urban homeless people differed when asked why they had chosen to come to the county where they were interviewed. Urban homeless people (22.1%) were much more likely to have moved to the county to look for work than were non-urban people (8.1%), while non-urban homeless people (43.7%) were more likely to have moved to be near friends and relatives than urban people (19.7%). These findings indicate that jobs, at least in Ohio, may be perceived to be more readily available in urban than non-urban areas. Additionally, non-urban homeless people appear to require or utilize family networks for help more so than urban people. See Table U9.

Table U9

Reason for Non-Permanent Residents Coming to County

REASON	URBAN Number	URBAN %	NON-URBAN Number	NON-URBAN %	TOTAL Number	TOTAL %
To live with relative or friend	90	19.7	59	43.7	149	25.2
To look for a job	101	22.1	11	8.1	112	19.0
Other reasons	63	13.8	24	17.8	87	14.7
Just another stop while passing through	48	10.5	13	9.6	61	10.3
To take a job	40	8.8	12	8.9	52	8.8
For public sleeping shelters	30	6.6	3	2.2	33	5.6
Lived here before	25	5.5	9	6.7	34	5.8
For social service programs	8	1.8	1	0.7	9	1.5
To go to school	9	2.0	0	0.0	9	1.5
Heard you could get on welfare	4	0.9	2	1.5	6	1.0
For community kitchens	4	0.9	0	0.0	4	0.7
Less police hassle	2	0.3	0	0.0	2	0.4
No answer	32	7.0	1	0.7	33	5.6
Total	456	100.0	135	99.9	591	100.0

Employment and Income

Respondents were asked whether or not they had worked during the last month. Of the urban respondents, 22.2 percent reported having worked as compared to 35.4 percent from non-urban areas (average of 42.7 percent of the mixed county respondents and 26.7 percent of the rural respondents). This may be explained in that jobs may be more readily available in non-urban areas, non-urban people may have to work because of the absence of other alternatives (e.g. shelters, missions), or non-urban families and friends may insist on homeless relatives working.

Those who reported having worked during the past month were asked to indicate what kinds of jobs they held. Nearly one-third (32.8%) of those non-urban respondents held permanent full-time jobs as compared to about one-fifth (21.7%) of urban respondents. By contrast, urban respondents (40.6%) tended to hold day labor jobs, while non-urban respondents (19.4%) had not. Urban (22.3%) and non-urban (29.8%) differences were small for temporary jobs. These findings may reflect the fact that in cities, many organizations offer day jobs to homeless people, a resource which may not exist in non-urban areas. See Table U10.

Table U10

Type of Work Done by Those Who Had Worked
in the Past Month

TYPE	URBAN Number	URBAN %	NON-URBAN Number	NON-URBAN %	TOTAL Number	TOTAL %
Day labor	71	40.6	13	19.4	84	34.7
Permanent, full-time	38	21.7	22	32.8	60	24.8
Temporary job	39	22.3	20	29.8	59	24.4
Permanent, part-time	15	8.6	9	13.4	24	9.9
Other	10	5.7	3	4.5	13	5.4
No answer	2	1.1	0	0.0	2	0.8
Total	175	100.0	67	99.9	242	100.0

Urban/non-urban homeless people did not differ in the extent to which they had ever held a job. Close to nine out of ten in both urban (85.8%) and non-urban (93.6%) groups reported having worked sometime during their adult lives.

Those who have not worked in the past month but who have held jobs during their adult lifetime were asked in what year they last worked. Nearly one-third (33.6%) of the urban respondents, and one-half (54.5%) of the non-urban homeless people, worked in the last eighteen months (since 1983). If the time interval is increased to include the last six years (since 1978), then 72.2 percent of the urban homeless sample and 84.5 percent of the non-urban homeless sample worked. See Table U11.

Table U11

Year Last Worked for Those Who Have Not Worked
During the Past Month

YEAR	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
1983 to 1984	169	33.6	60	54.5	229	37.4
1978 to 1982	194	38.6	33	30.0	227	37.0
1969 to 1977	78	15.5	9	8.2	87	14.2
1968 and earlier	25	5.0	6	5.5	31	5.1
No answer	37	7.3	2	1.8	39	6.3
Total	503	100.0	110	100.0	613	100.0

Respondents were asked why the job they last held had ended. Reasons related to the company (job temporary, plant closing, lay-off) and to the individual (fired, quit, health, substance abuse, mental health) were identified. Urban homeless people (36.9%) were only slightly more likely to have lost their jobs for a company-related reason than were non-urban homeless people (32.8%). See Table U12.

Table U12

Reason of Formerly Employed Respondents
for Last Job Ending

REASON	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Quit	82	16.3	24	21.8	106	17.3
Temporary job	82	16.3	18	16.4	100	16.3
Fired	72	14.3	21	19.1	93	15.2
Company closed/moved	54	10.7	8	7.3	62	10.1
Laid off	50	9.9	10	9.1	60	9.8
Other reasons	48	9.5	11	10.0	59	9.6
Poor physical health	44	8.7	13	11.8	57	9.3
Drinking/drugs	32	6.4	1	0.9	33	5.4
Poor mental health	16	3.2	3	2.7	19	3.1
Went to prison/jail	9	1.8	1	0.9	10	1.6
CETA benefits ended	2	0.4	0	0.0	2	0.3
No answer	12	2.4	0	0.0	12	2.0
Total	503	99.9	110	100.0	613	100.0

By far, the major reason cited by homeless people for not working involved their inability to find a job. However, non-urban people (61.8%) were much more likely to have had this difficulty, than were urban people (43.9%). See Table U13.

Table U13

Reason of Formerly Employed Respondents for Not Working Now

REASON	URBAN Number	URBAN %	NON-URBAN Number	NON-URBAN %	TOTAL Number	TOTAL %
Looked, but cannot find work	221	43.9	68	61.8	289	47.1
Disabled/cannot work	109	21.7	18	16.4	127	20.7
Other reasons	48	9.5	8	7.3	56	9.1
Plan to look for work	31	6.2	3	2.7	34	5.5
Do not want to work	27	5.4	2	1.8	29	4.7
Do not feel ready to work	25	5.0	4	3.6	29	4.7
To stay home with children	14	2.8	5	4.5	19	3.1
Alcohol/drug problem	9	1.8	0	0.0	9	1.5
Do not know where to look for work	8	1.6	0	0.0	8	1.3
Do not want to lose benefits	3	0.6	1	0.9	4	0.7
Do not need to work	3	0.6	0	0.0	3	0.5
Poor education	3	0.6	0	0.0	3	0.5
No answer	2	0.4	1	0.9	3	0.5
Total	503	100.1	110	99.9	613	99.9

Almost two-thirds (63.5%) of those in the study reported having had income during the past month. Non-urban respondents (79.4%) were much more likely to have reported income than urban respondents (59.8%).

In order to explain differences among those homeless people in urban/non-urban populations who reported having income, they were asked from what source they received income. Few differences were observed across groups. Urban homeless people were more likely to cite welfare and social security as their primary source of income, whereas non-urban homeless respondents were more likely to report income from earnings as their primary source of funds during the past month. Homeless people receive relatively little from family and friends, charity, pensions, missions and shelter work, and blood banks. See Table U14.

Table U14

Primary Income Source for Respondents Who Had Income in the Past Month

SOURCE	URBAN Number	URBAN %	NON-URBAN Number	NON-URBAN %	TOTAL Number	TOTAL %
Welfare	181	38.3	52	34.7	233	37.5
Earnings	120	25.4	47	31.3	167	26.8
Social Security	100	21.2	24	16.0	124	19.9
Other sources	15	3.2	6	4.0	21	3.4
Family/friends	10	2.1	9	6.0	19	3.1
Refused to disclose	14	3.0	0	0.0	14	2.3
Pension	9	1.9	4	2.7	13	2.1
Charity	10	2.1	1	0.7	11	1.8
Mission/shelter work	3	0.6	6	4.0	9	1.4
Giving blood	9	1.9	0	0.0	9	1.4
No answer	1	0.2	1	0.7	2	0.3
Total	472	99.9	150	100.1	622	100.0

Social Service Usage

Homeless people were asked about their use of shelters, community mental health centers, soup kitchens, hospital emergency rooms, welfare or general relief, and shelters for battered women. No substantial urban/non-urban differences were observed in the use of community mental health centers (11.5% and 14.8% respectively) or hospital emergency rooms (23.3% and 29.6% respectively).

Differences were observed in the use of other services. Because of shelter availability in cities, urban homeless people (64.0%), were more likely to use them than were non-urban people (24.3%). Similarly, again because of availability, urban homeless people (67.2%) are much more likely to take meals from soup kitchens than non-urban homeless people (33.8%). By contrast, non-urban homeless people (61.4%) received welfare and general relief payments to a greater extent than urban homeless people (40.4%). One potential explanation may be that non-urban people may be more able to establish an address as required by the Welfare system than would be the case with city dwellers, given the higher proportion of non-urban homeless people in close contact with friends or relatives. Finally, women who are homeless in the city (18.6%) tend to use battered women's shelters more than their non-urban counterparts (4.0%). Once more, the availability of these shelters primarily in urban areas would appear to be a factor. See Table U15.

Table U15

Social Service Usage

SOCIAL SERVICE	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Community kitchens	531	67.2	64	33.8	595	60.8
Shelters	506	64.0	46	24.3	552	56.4
Welfare/general relief	319	40.4	116	61.4	435	44.4
Hospital emergency rooms	184	23.3	56	29.6	240	24.5
Shelters for battered women	21	18.6	2	4.0	23	12.4
Community mental health centers	91	11.5	28	14.8	119	12.2

Obtaining food is a major concern of homeless people. When asked where they took their meals, urban and non-urban responses did not differ with regard to restaurants, food pantries, dumpsters, trash, vending machines, stealing, shelters, and families. Major differences appeared in the following ways: urban respondents (51%) were much more likely to use soup kitchens than were non-urban respondents (11.6%, the average of 17.5 percent of the mixed county respondents and 4.7 percent of rural respondents). This reflects, in part, the availability of soup kitchen facilities in urban areas and the existence of other alternatives in non-urban areas. One alternative appears to be the capacity of non-urban homeless people (30.2%) to purchase food from grocery stores for their own preparation, and the incapacity of urban homeless people (13.4%) to do the same. As an alternative, obtaining handouts for non-urban homeless people (22.2%) is more prevalent than it is for urban homeless people (9.5%). See Table U16.

Table U16

Primary Source of Meals

PRIMARY FOOD SOURCE	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Community kitchen	403	51.0	22	11.6	425	43.4
Buy at store; cook one's own	106	13.4	57	30.2	163	16.6
Handouts	75	9.5	42	22.2	117	12.0
Restaurant	57	7.2	11	5.8	68	6.9
Family and friends	33	4.2	16	8.5	49	5.0
Other sources	38	4.8	8	4.2	46	4.7
Missions/shelters	29	3.7	5	2.6	34	3.5
Food pantry; cook one's own	14	1.8	13	6.9	27	2.8
Do without	18	2.3	9	4.8	27	2.8
Dumpsters; trash	11	1.4	4	2.1	15	1.5
Vending machines	1	0.1	1	0.5	2	0.2
Stealing	2	0.2	0	0.0	2	0.2
No answer	3	0.4	1	0.5	4	0.4
Total	790	100.0	189	99.9	979	100.0

Psychiatric Hospitalization

When asked about having been hospitalized for emotional or mental health problems, urban (30.6%) and non-urban (27%) homeless people differed little in their responses. Nearly three in ten homeless people had been hospitalized.

Among those who indicated that they had been hospitalized (N=293), several urban/non-urban differences were apparent concerning types of hospitalization. Urban homeless people (7.0%) were more likely to have been hospitalized by the Veteran's Administration than were non-urban homeless people (2.6%). This might be explained because of the greater proportion of veterans in the urban (33.4%) than non-urban (24.3%) sample. By contrast, non-urban homeless people (15.3%) were more likely to have been hospitalized in a general or private hospital than urban people (12.7%). This may be the result of the absence of other kinds of facilities. Treatment in a state psychiatric hospital was more prevalent among urban homeless people (19.6%) than among non-urban (13.2%). See Table U17 for a description of psychiatric hospitalization.

Table U17

Psychiatric Hospitalization

HOSPITALIZATION	URBAN Number	URBAN %	NON-URBAN Number	NON-URBAN %	TOTAL Number	TOTAL %
Never been hospitalized	536	67.8	137	72.5	673	68.7
Been hospitalized	242	30.6	51	27.0	293	29.9
(Veteran's hospital)	(55	7.0)	(5	2.6)	(60	6.1)
(General hospital)	(100	12.7)	(29	15.3)	(129	13.2)
(State hospital)	(155	19.6)	(25	13.2)	(180	18.4)
No answer	12	1.5	1	0.5	13	1.3
Total	790	99.9	189	100.0	979	99.9

* Hospitalized subtotals do not add to the percentages listed as "Been hospitalized" because some respondents have had hospitalizations in more than one type of setting.

No urban/non-urban differences were noted concerning the number of times hospitalized for those ever hospitalized in a state psychiatric facility. The mean number of times hospitalized was 3.7 for urban respondents and 3.4 for non-urban respondents. The median number of times hospitalized was two for each group. See Table U18.

Table U18

Number of Times Hospitalized for Those Ever Hospitalized in a State Psychiatric Facility

TIMES HOSPITALIZED	URBAN Number	URBAN %	NON-URBAN Number	NON-URBAN %	TOTAL Number	TOTAL %
one	62	40.0	8	32.0	70	38.9
two	24	15.5	5	20.0	29	16.1
3 - 4	23	14.8	4	16.0	27	15.0
5 - 6	16	10.3	2	8.0	18	10.0
7 or more	18	11.6	3	12.0	21	11.7
No answer	12	7.7	3	12.0	15	8.3
Total	155	99.9	25	100.0	180	100.0
Mean number of times	3.7		3.4		3.7	
Median number of times	2.0		2.0		2.0	

Table U19 shows the year in which homeless people were last released from a state psychiatric hospital. Because of the small sample of non-urban respondents, results should be treated with caution. However, in both urban and non-urban populations, almost one-half (45.2% and 48% respectively) were released within the past two years. Nearly one-fourth (22.5%) of the urban sample and one-third (32.0%) of the non-urban sample who had a state psychiatric hospitalization were released in 1978 or earlier.

Table U19

Year Last Released for Those Ever Hospitalized
in a State Psychiatric Hospital

YEAR	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
1984 - 1983	70	45.2	12	48.0	82	45.5
1982 - 1981	23	14.8	0	0.0	23	12.8
1980 - 1979	12	7.7	2	8.0	14	7.8
1978 - 1970	23	14.8	6	24.0	29	16.1
1969 or before	12	7.7	2	8.0	14	7.8
No answer	15	9.7	3	12.0	18	10.0
Total	155	99.9	25	100.0	180	100.0

Reported living arrangements after release from hospitals, after psychiatric treatment was received, also yielded urban/non-urban differences: urban discharges (19.3%) were much less likely to be released to families than were non-urban discharges (48.0%). This may indicate the absence of strong family ties among urban homeless people. Unlike non-urban people (4%), urban people (12.2%) were more likely to be released to their own home or apartment. Similarities were also observed. Discharges to group homes and hotels/motels were common for both urban and non-urban populations. A difference was noted in the lack of living arrangements after discharge for urban people (36.8%) as compared to non-urban (24%) homeless people, however, this may be the result of the small sample size rather than a valid difference. For the 108 respondents who said arrangements were made for them, 95 (88.0%) said that they went to that arranged place to live. Urban and non-urban respondents were nearly identical in percentages--87.6 and 89.5, respectively. See Table U20 for a description of reported living arrangements for respondents released from state psychiatric hospitals.

Table U20

Reported Living Arrangements for Respondents
Released from State Hospitalization

RELEASED TO	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
No arrangements were made	57	36.8	6	24.0	63	35.0
Family	30	19.3	12	48.0	42	23.3
Other arrangements	18	11.6	3	12.0	21	11.6
Own apartment or house	19	12.2	1	4.0	20	11.1
Group home	16	10.3	2	8.0	18	10.0
Hotel/motel	6	3.9	1	4.0	7	3.9
No answer	9	5.8	0	0.0	9	5.0
Total	155	99.9	25	100.0	180	99.9
Arrangements were made (N=108)						
Went to the place arranged for them (N=95)	78	87.6	17	89.5	95	88.0

When the 180 respondents who had been in state psychiatric hospitals were asked about referrals to community mental health centers, a total of 100 (55.5%) said that they had been referred. However, non-urban homeless people (76%) were more likely to report being referred to a community mental health center than was the case for urban homeless people (52.6%). This suggests that the referral networks in non-urban areas may be more efficient than those in cities.

Homeless people in non-urban areas (68.4%) reported a higher rate of contacting a community mental health center than did homeless people in cities (53.1%). See Table U21.

Table U21

Contact with a Community Mental Health Center for Those Referred

TYPE OF CONTACT	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
I contacted them	43	53.1	13	68.4	56	56.0
They contacted me	11	13.6	1	5.3	12	12.0
No contact	25	30.8	4	21.0	29	29.0
No answer	2	2.5	1	5.3	3	3.0
Total	81	100.0	19	100.0	100	100.0

When asked how they would feel about returning to a state hospital if they were having emotional problems again, no urban/non-urban differences were found: nearly one-half (52.9% and 52% respectively) said they did not wish to return. See Table U22.

Table U22

Feelings about Returning to a State Hospital by Those Ever Hospitalized

FEELINGS	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Not want to go back	82	52.9	13	52.0	95	52.8
Not mind going back	43	27.7	8	32.0	51	28.3
Like to go back	20	12.9	2	8.0	22	12.2
Not thought about it	5	3.2	2	8.0	7	3.9
Would go back for shelter	1	0.6	0	0.0	1	0.6
No answer	4	2.6	0	0.0	4	2.2
Total	155	100.0	25	100.0	180	100.0

Social Network

More non-urban homeless persons (43.4%) said they had relatives they could count on than did urban homeless persons (34.2%), while 42.8 percent of the total respondents said they had relatives, but that they could not count on them for help. More urban homeless persons said that they had no relatives than did homeless respondents in non-urban counties (22.5% vs. 9.5%). See Table U23.

Table U23

"Do you have relatives you can count on for help?"

RESPONSE	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Yes	270	34.2	82	43.4	352	36.0
No, can't count on	330	41.8	89	47.1	419	42.8
No, no relatives	178	22.5	18	9.5	196	20.0
No answer	12	1.5	0	0.0	12	1.2
Total	790	100.0	189	100.0	979	100.0

There were differences between urban and non-urban homeless people in terms of when they last saw their relatives. Non-urban homeless people have more contact with relatives than urban homeless people. Almost 60 percent of non-urban homeless people had had contact with relatives within the past seven days, compared to only 37.7 percent of urban homeless people. See Table U24.

Table U24

Time Since Contact with Relatives
for Those Who Have Relatives

DAYS	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
1 - 7	226	37.7	101	59.1	327	42.4
8 - 30	119	19.8	25	14.6	144	13.7
31 - 90	75	12.5	12	7.0	87	11.3
91 - 180	36	6.0	6	3.5	42	5.4
181 - 365	37	6.2	9	5.3	46	6.0
366 or more	79	13.2	14	8.2	93	12.1
No answer	28	4.7	4	2.3	32	4.1
Total	600	100.1	171	100.0	771	100.0
Mean number of days	301.9		169.9		284.5	
Median number of days	14.0		4.0		14.0	

However, when urban and rural respondents who had had no contact with relatives within the past thirty days were asked why not, no differences among reasons were found.

Respondents who had not had contact with their relatives during the past month were asked the major reason for such infrequent contact. No substantial urban/non-urban differences were noted. See Table U25.

Table U25

Reasons for Infrequent Contact with Relatives
for Those Who Have Not Had Contact for More Than One Month

REASONS	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
No desire to maintain relationship	50	22.0	12	29.3	62	23.1
Relatives do not want to see me	46	20.3	9	21.9	55	20.5
Relatives do not live nearby	47	20.7	8	19.5	55	20.5
They would not help	28	12.3	6	14.6	34	12.7
Other reasons	17	7.5	3	7.3	20	7.5
I'm ashamed of current situation	10	4.4	2	4.9	12	4.5
It has been too long since I've seen them	10	4.4	0	0.0	10	3.7
Do not know where they are	4	1.8	0	0.0	4	1.5
They cannot help me/they need help too	3	1.3	0	0.0	3	1.1
No transportation	1	0.4	0	0.0	1	0.4
No answer	11	4.8	1	2.4	12	4.5
Total	227	99.9	41	99.9	268	100.0

More non-urban homeless people (57.1%) than urban homeless people (37.1%) said they had friends they could count on for help. Similarly, only 12.7 percent of non-urban homeless people said they have no friends as compared to 30.1 percent of urban homeless people. This would indicate that non-urban homeless people have a more intimate social network of friends than urban homeless people. See Table U26.

Table U26

"Do you have friends you can count on for help?"

RESPONSE	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Yes	293	37.1	108	57.1	401	41.0
No, can't count on	251	31.8	56	29.6	307	31.4
No, no friends	238	30.1	24	12.7	262	26.8
No answer	8	1.0	1	0.5	9	0.9
Total	790	100.0	189	99.9	979	100.1

However, no differences across groups were noted when respondents who indicated they did have friends were asked if they had enough close friends. A little over one-half of each group said they thought they had enough close friends. See Table U27.

Table U27

"Do you have enough close friends?"

RESPONSE	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Yes	292	53.8	90	54.5	382	54.0
No	241	44.4	74	44.8	315	44.5
No answer	10	1.8	1	0.6	11	1.5
Total	543	100.0	165	99.9	708	100.0

Non-urban homeless persons seem to have a little more frequent contact with friends than urban homeless people. Seventy-seven percent of the non-urban respondents said they had had contact within the last seven days versus 69.1 percent of the urban respondents. See Table U28.

Table U28

Time Since Contact with Friends for Those Who Have Friends

DAYS	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
1 - 7	375	69.1	127	77.0	502	70.9
8 - 30	56	10.3	12	7.3	68	9.6
31 - 90	23	4.2	8	4.8	31	4.4
91 - 180	14	2.6	3	1.8	17	2.4
181 - 365	13	2.4	6	3.6	19	2.7
366 or more	19	3.5	4	2.4	23	3.2
No answer	43	7.9	5	3.0	48	6.8
Total	543	100.0	165	99.9	708	100.0
Mean number of days	91.6		46.3		80.5	
Median number of days	1.0		1.0		1.0	

Physical Health Problems

Overall, 30.7 percent of the respondents reported current medical problems. When the urban/non-urban rate was compared, there were no differences (31% and 29.6% respectively). However, when the three county types were examined, differences were found (rates of 31% in urban counties, 20.4% in mixed counties, and 41% in rural counties).

When people were asked whether they had health problems needing medical assistance, no systematic urban/non-urban differences were observed. See Table U29.

Table U29

Physical Health Problems

PROBLEM	URBAN Number	URBAN %	NON-URBAN Number	NON-URBAN %	TOTAL Number	TOTAL %
Reported no physical problems	536	67.8	133	70.4	669	68.3
Reported physical problems	245	31.0	56	29.6	301	30.7
Ill-defined conditions	(70)	(8.9)	(19)	(10.0)	(89)	(9.1)
Arthritis, rheumatism and other diseases of the musculoskeletal system	(38)	(4.8)	(11)	(5.8)	(49)	(5.0)
Injury and Poisoning	(38)	(4.8)	(4)	(2.1)	(42)	(4.3)
Diseases of the heart and circulatory system	(33)	(4.2)	(5)	(2.6)	(38)	(3.9)
Diseases of the nervous system and sense organs	(27)	(3.4)	(7)	(3.7)	(34)	(3.5)
Diseases of the respiratory system	(24)	(3.0)	(6)	(3.2)	(30)	(3.1)
Diseases of the digestive system	(21)	(2.7)	(7)	(3.7)	(28)	(2.9)
Eye Problems	(18)	(2.3)	(4)	(2.1)	(22)	(2.2)
Endocrine and nutritional disorders	(14)	(1.8)	(4)	(2.1)	(18)	(1.8)
Dental Problems	(14)	(1.8)	(2)	(1.0)	(16)	(1.6)
Infections and parasitic disorders	(8)	(1.0)	(3)	(1.6)	(11)	(1.1)
Neoplasms (cancer and benign tumors)	(7)	(0.9)	(3)	(1.6)	(10)	(1.0)
Diseases of the genito-urinary system	(6)	(0.7)	(4)	(2.1)	(10)	(1.0)
Pregnancy	(6)	(0.7)	(3)	(1.6)	(9)	(0.9)
Diseases of the blood	(6)	(0.7)	(2)	(1.0)	(8)	(0.8)
Alcoholism	(6)	(0.7)	(0)	(0.0)	(6)	(0.6)
Diseases of the skin	(4)	(0.5)	(0)	(0.0)	(4)	(0.4)
No answer	(2)	(0.2)	(2)	(1.0)	(4)	(0.4)
No answer	9	1.1	0	0.0	9	0.9
Total	790	100.0	189	100.0	979	99.9

Note: Subtotals for types of problems do not add to "Reported physical problems" because 127 respondents indicated they had two problems.

Respondents were asked if they had taken any drugs or medications in the past month, and if so, whether these had been prescribed by a doctor. Only about one-third of either the urban (31.9%) or non-urban (33.3%) homeless people reported having taken any drugs during the past month. Of those taking drugs, urban (67.3%) respondents were less likely to have taken prescribed drugs than non-urban respondents (66.7%). Few of those taking drugs reported experiencing a problem: only 14.7 percent of the urban respondents and 15.9 percent of the non-urban sample had trouble. See Table U30.

Table U30

Usage of Drugs and Medications Within the Past Month

USAGE CATEGORY	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Use drugs or medications (N=979)						
Yes	252	31.9	63	33.3	315	32.2
No	532	67.3	126	66.7	658	67.2
No answer	6	0.8	0	0.0	6	0.6
Total	790	100.0	189	100.0	979	100.0
If used drugs/medications (N=315)						
A. Drugs/medications are prescribed						
Yes	172	68.3	49	77.8	221	70.2
No	64	25.4	13	20.6	77	24.4
Some were; some weren't	14	5.6	1	1.6	15	4.8
No answer	2	0.8	0	0.0	2	0.6
Total	252	100.1	63	100.0	315	100.0
B. Trouble with drugs/medications						
Yes	37	14.7	10	15.9	47	14.9
No	199	79.0	51	81.0	250	79.4
No answer	16	6.3	2	3.1	18	5.7
Total	252	100.0	63	100.0	315	100.0

Respondents were asked about their drinking behavior during the past month. Slightly less than half of urban (44.2%) and non-urban respondents (48.7%) reported drinking "some", however, nearly twice as many urban (21.3%) as non-urban respondents (10.6%) reported they had been drinking a lot. See Table U31.

Table U31

Reported Drinking During the Past Month

AMOUNT OF DRINKING	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Some	349	44.2	92	48.7	441	45.0
A lot	168	21.3	20	10.6	188	19.2
Not at all	268	33.9	77	40.7	345	35.2
No answer	5	0.6	0	0.0	5	0.5
Total	790	100.0	189	100.0	979	99.9

Urban (28.1%) homeless people were somewhat more likely to report seeking help for a drinking problem than non-urban people (20.1%). This may be the result of service availability in urban versus non-urban areas. See Table U32.

Table U32

Seeking Help for Drinking

BEHAVIOR	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Have ever sought help	222	28.1	38	20.1	260	26.6
Have not sought help	543	68.7	150	79.4	693	70.8
No answer	25	3.2	1	0.5	26	2.7
Total	790	100.0	189	100.0	979	100.1

General Well-being

There were no substantial urban/non-urban differences on the two questions used to obtain a meaningful assessment of the way homeless persons evaluated themselves in terms of mental health. See Tables U33 and U34.

Table U33

"How would you rate your nerves, spirits, outlook,
or mental health at present?"

RESPONSE	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Excellent	77	9.7	13	6.9	90	9.2
Good	239	30.2	66	34.9	305	31.2
Fair	274	34.7	64	33.9	338	34.5
Poor	125	15.8	27	14.3	152	15.5
Very bad	60	7.6	17	9.0	77	7.9
No answer	15	1.9	2	1.1	17	1.7
Total	790	99.9	189	100.1	979	99.9

Table U34

"In general, how satisfying would you say your life has been?"

RESPONSE	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
Very satisfying	80	10.1	16	8.5	96	9.8
Somewhat satisfying	189	23.9	43	22.7	232	23.7
Mixed	282	35.7	78	41.3	360	36.8
Not very satisfying	161	20.4	35	18.5	196	20.0
Not at all satisfying	63	8.0	16	8.5	79	8.1
No answer	15	1.9	1	0.5	16	1.6
Total	790	100.0	189	100.0	979	100.0

These results would seem to indicate that a surprisingly large percentage of homeless people rate their general well-being as relatively good, despite their circumstances. However, comparative data on these same two items from two samples of 2,183 people in five rural southern Ohio counties (see Tables S33 and S34 in the Statewide Report) indicate that the general population rates its mental health as being substantially better than does the homeless population.

TYPES OF HOMELESSNESS COMPARISONS

A major concern of this study was to focus on the many varieties of homelessness, not just on street or shelter people, as has been done in numerous other studies. The primary reason for this focus was the assumption that homelessness is a much more complicated problem than service needs for those on the street and in shelters. By casting the net fairly widely, a more comprehensive picture can be developed.

Homeless people may be classified in many ways. One way is to separate people according to cause of homelessness. This would involve developing categories like psychological problems, family conflict, unemployment, natural disasters, etc. Another way is to focus on life-style concerns. Categories here might be those that appear in the popular literature such as the hobo/vagabond/happy wanderer, street people, shelter people, and so on. There are others. In this survey, homeless people were separated in the initial sampling plan on the basis of where they spent the previous night. These locations or sites were categorized according to the "degree of exposure to the elements" as follows:

- No shelter
- Automobile, abandoned building, public facility (e.g., bus station, public lobby, etc.)
- Mission or shelter
- Cheap motel or hotel (e.g., single room only) for less than 45 days
- Temporarily with family or friends for less than 45 days
- Other unique conditions

Stratifying the sample by type of living accommodation made it possible to create a representative picture of the entire homeless population, and also allowed for an analysis which could look at people experiencing different kinds of problems--that is, living in an alleyway versus staying at a shelter, or being shuffled from relative to relative.

Three Types of Homelessness

The classification above is limited because it does not take into account that people may be on the street one night and in a shelter the next. In order to derive a more meaningful classification for purposes of this analysis, information on where respondents slept last night was combined with whether they had used a shelter or mission the past month to yield the following groups:

- **Street People:** Those who had limited or no shelter the night before and who reported no shelter use for at least one month.
- **Shelter People:** Those who slept in a shelter the night before or who reported doing so any time during the last month.
- **Resource People:** Those who stayed in a cheap hotel/motel or with family or friends the night before and who had not stayed at a shelter during the past month.

Results of the analysis showed that 943 of the total number of respondents could be classified according to one of the three newly-defined groups: 139 Street People (14.2%), 562 Shelter People (57.4%), and 242 Resource People (24.7%). Thirty-six people could not be classified under this scheme. See Table T1 A.

Table T1 A

Definition of Three Types of Homelessness*

PLACE SLEPT LAST NIGHT	Stayed in a Shelter During the Past Month			
	Yes	No	No Answer	Total
Limited or no shelter	147[2]	139[1]	2[4]	288
Missions, shelters	300[2]	11[2]	3[4]	314
Cheap motels/hotels	54[2]	116[3]	1[4]	171
Family or friends	36[2]	126[3]	—	162
Unique conditions	14[2]	28[4]	—	42
No answer	1[4]	1[4]	—	2
Total	552	421	6	979

* Total number of people classified = 943
1 Classified as Street People (N=139)
2 Classified as Shelter People (N=562)
3 Classified as Resource People (N=242)
4 No answers or could not be classified (N=36)

These categories seemed to measure the amount of resourcefulness, the type of individual or personal problems, or the nature of preferences among homeless people. Some caveats are necessary. Street People, as defined above, have the highest level of exposure to the environment. Lack of shelter may occur as a result of the following: they were denied a place to stay because of limited shelter space; their preference was to remain away from human contact or social services; they lack friends or relatives on whom they can count; they have a shortage of money or other resources, or they were not admitted to a shelter because of a personal problem (e.g., drunkeness, drug abuse, traveling with an unmarried mate, etc.). Shelter People may be, on occasion, indistinguishable from Street People, the only difference being that shelter space was available, they overcame their aversion to seeking help, or they overcame or resolved a personal problem sufficient enough to be admitted. Resource People, by contrast, seem very different from either Street or Shelter People, because of their support network of friends or relatives, along with some personal resources. Even though they have some resources, they are truly homeless and may have been or may become Street or Shelter People.

In all subsequent analyses in this section of the report concerning Types of Homelessness comparisons, the base number of 943 will be used, and all percentages will be calculated on that base.

Differences were noted when comparing type of homelessness by region and county. Primarily due to the sampling plan (see Introduction section of this report), over half (51.1%) of all respondents classified as Street People were interviewed in the northeast region. On the other hand, the central region, including the city of Columbus, accounted for only 8.6 percent of the respondents classified as Street People.

Only 4.3 percent of the shelter respondents classified as Shelter People were interviewed in the southeast region. This is understandable due to the lack of shelters in the sample counties in that region. The bulk of respondents classified as Shelter People came from Cuyahoga County (27.0%) and Hamilton County (24.9%).

The northeast, central, and southwest regions accounted for 78.1 percent of all respondents classified as Resource People. See Table T1.

Table T1

Interviews Completed
(N=943)

REGION/COUNTY	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Northeast Region	71	51.1	221	39.2	74	30.5	366	38.8
Cuyahoga	66	47.5	152	27.0	64	26.4	282	29.9
Ashland	1	0.7	10	1.7	2	0.8	13	1.4
Geauga	0	0.0	0	0.0	0	0.0	0	0.0
Holmes	0	0.0	0	0.0	0	0.0	0	0.0
Mahoning	4	2.9	59	10.5	8	3.3	71	7.5
Northwest Region	20	14.4	93	16.6	30	12.4	143	15.2
Lucas	13	9.3	91	16.2	21	8.7	125	13.3
Wood	5	3.6	0	0.0	6	2.5	11	1.2
Paulding	0	0.0	0	0.0	2	0.8	2	0.2
Fulton	2	1.4	2	0.4	1	0.4	5	0.5
Central Region	12	8.6	76	13.5	56	23.1	144	15.3
Franklin	8	5.8	72	12.8	28	11.6	108	11.5
Union	1	0.7	0	0.0	10	4.1	11	1.2
Wyandot	0	0.0	1	0.2	16	6.6	17	1.8
Pickaway	3	2.2	3	0.5	2	0.8	8	0.8
Southeast Region	7	5.0	24	4.3	23	9.5	54	5.7
Jefferson	2	1.4	19	3.4	9	3.7	30	3.2
Washington	2	1.4	3	0.5	1	0.4	6	0.6
Noble	2	1.4	0	0.0	6	2.5	8	0.8
Hocking	1	0.7	2	0.4	7	2.9	10	1.1
Southwest Region	29	20.9	148	26.4	59	24.4	236	25.1
Hamilton	14	10.0	140	24.9	25	10.3	179	19.0
Clermont	11	7.9	1	0.2	15	6.2	27	2.9
Brown	4	2.8	2	0.4	5	2.1	11	1.2
Logan	0	0.0	5	0.9	14	5.8	19	2.0
Total	139	100.0	562	100.0	242	99.9	943	100.1

Demographics

Sex. Homeless people are perceived by many observers to be primarily male. This impression probably is continually reinforced when homeless people are equated with Street or Shelter People--the image of men of the Bowery.

When the homeless population was separated into our typology, it became clear that images of the homeless group as being all male is derived from observations of only Street and Shelter People rather than from a wider focus which includes others (i.e., the Resource type). Street People were nearly all male (89.2%). It is much more difficult for females to sustain this life style and females may have greater resources. The Shelter group was made up somewhat less of males (82.9%). This suggests that females are slightly more likely to gain access to shelters than to remain on the street. Females, however, made up 28.5 percent of the Resource People.

If homelessness is defined as in this study, it may be the case that homelessness is much more of a problem for women than has been implied in other studies.

Ethnicity. Analysis by type of homelessness showed that Street People (72.0%) were slightly more likely to be white than were Shelter (63.3%) or Resource (64.0%) People.

Veteran Status. Type of homelessness did account for some differences in veteran status. Shelter People (36.7%) were much more likely to be veterans than Street (29.5%) People or especially Resource (22.3%) People. Consequently, being a veteran may have contributed to or been associated with homelessness for some people.

Marital Status. When people were classified by type of homelessness, few differences in marital status emerged. One exception was that Resource People were less likely to be divorced than were either Street or Shelter People.

Education. Type of homelessness showed no association with education levels. Street (40.2%), shelter (46.6%), and resource (45.8%) people all were comparably educated.

Age. Again, possibly because homeless people are often equated with Shelter People, homeless people are thought to be older. Differences in age of the homeless population were reflected when type of homelessness was taken into account. A little more than one-half of those in the Street (51.1%) and Shelter (56.9%) population were under 40 years of age, as compared with nearly four-fifths (80.2%) for the Resource People.

Jail/Prison. When asked about their experiences, more than one-half (57.8%) of the overall sample said they were incarcerated at some time. Types of homelessness revealed some clear differences among groups. Shelter (63.5%) and Street (58.3%) People were much more likely than Resource People (44.2%) to have been jailed. See Table T2 for a detailed breakdown on demographics.

Table T2

Demographics by Type of Homelessness

CHARACTERISTIC	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
SEX								
Male	124	89.2	466	82.9	173	71.5	763	81.0
Female	15	10.8	96	17.1	69	28.5	180	19.0
Total	139	100.0	562	100.0	242	100.0	943	100.0
ETHNICITY								
White	100	71.9	356	63.3	155	64.0	611	64.8
Black	35	25.2	180	32.0	70	28.9	285	30.2
Hispanic	3	2.2	17	3.0	13	5.4	33	3.5
Other	0	0.0	3	0.5	3	1.2	6	0.6
No answer	1	0.7	6	1.1	1	0.4	8	0.8
Total	139	100.0	562	99.9	242	99.9	943	99.9
AGE								
18 - 29 years	37	26.6	171	30.4	120	49.6	328	34.7
30 - 39 years	34	24.5	149	26.5	74	30.6	257	27.3
40 - 49 years	29	20.9	105	18.7	26	10.7	160	17.0
50 - 59 years	24	17.3	90	16.0	14	5.8	128	13.6
60 years and over	13	9.4	40	7.1	6	2.5	59	6.3
No answer	2	1.4	7	1.2	2	0.8	11	1.2
Total	139	100.1	562	99.9	242	100.0	943	100.1
EDUCATION								
No formal schooling	0	0.0	7	1.2	0	0.0	7	0.7
1 - 8 grades	25	18.0	103	18.3	27	11.2	155	16.4
9 - 11 grades	58	41.7	191	34.0	104	43.0	353	37.4
High school graduate	38	27.3	165	29.4	86	35.5	289	30.7
Some college	15	10.8	78	13.9	18	7.4	111	11.8
College graduate	2	1.4	16	2.9	4	1.7	22	2.3
No answer	1	0.7	2	0.4	3	1.2	6	0.6
Total	139	99.9	562	100.1	242	100.0	943	99.9
MARITAL STATUS								
Married	17	12.2	34	6.1	35	14.5	86	9.1
Separated	23	16.6	68	12.1	41	16.9	132	14.0
Widowed	2	1.4	32	5.7	8	3.3	42	4.5
Divorced	37	26.6	152	27.0	45	18.6	234	24.8
Never been married	56	40.3	264	47.0	101	41.7	421	44.6
Living together	2	1.4	7	1.2	12	5.0	21	2.2
No answer	2	1.4	5	0.9	0	0.0	7	0.7
Total	139	99.9	562	100.0	242	100.0	943	99.9
VETERAN STATUS								
Yes	41	29.5	206	36.7	54	22.3	301	31.9
(Vietnam Veteran)	(8	5.8)	(56	10.0)	(16	6.6)	(80	8.5)
No	97	69.8	355	63.2	186	76.9	638	67.7
No answer	1	0.7	1	0.2	2	0.8	4	0.4
Total	139	100.0	562	100.1	242	100.0	943	100.0
JAIL/PRISON								
Yes	81	58.2	357	63.5	107	44.2	545	57.7
No	54	38.9	202	35.9	134	55.4	390	41.4
No answer	4	2.9	3	0.5	1	0.4	8	0.9
Total	139	100.0	562	99.9	242	100.0	943	100.0

Homelessness

Length of Time Homeless. Differences were found between Street, Shelter and Resource People as to how long they had been homeless. Homeless Resource People have been homeless for less time (median of 35 days) than either Street People (median of 60 days) or Shelter People (median of 90 days). See Table T3.

Table T3

Length of Time Respondents Had Been Homeless

TIME	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
30 days or less	61	43.9	203	36.1	107	44.2	371	39.3
31 - 60 days	14	10.1	41	7.3	35	14.5	90	9.5
61 - 365 days	28	20.1	152	27.0	50	20.7	230	24.4
366 - 730 days	7	5.0	43	7.6	16	6.6	66	7.0
731 days or more	22	15.8	95	16.9	22	9.1	139	14.7
No answer	7	5.0	28	5.0	12	4.9	47	5.0
Total	139	99.9	562	99.9	242	100.0	943	99.9
Mean number of days	606.9		688.4		469.1		620.1	
Median number of days	60		90		35		60	

Reason for Homelessness

When findings were sorted into types of homelessness, there were not substantial differences between Street, Shelter, or Resource People in the reasons they reported for being homeless. Shelter People were slightly less likely to report economic reasons (47.0% vs. 51.8% for Street People, and 51.2% for Resource People). Street People were less likely to report family conflict/dissolution as the major reason (16.5% vs. 22.0% for Shelter People, and 21.5% for Resource People). See Table T5.

Table T5

Reported Major Reason for Homelessness

REASON	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Unemployment	26	18.7	133	23.7	52	21.5	211	22.4
Problems paying rent	24	17.3	68	12.1	39	16.1	131	13.9
Family conflict	12	8.6	85	15.1	29	12.0	126	13.4
Eviction	15	10.8	45	8.1	31	12.8	91	9.7
Other reasons	10	7.2	54	9.6	23	9.5	87	9.2
Family dissolution	11	7.9	39	6.9	23	9.5	73	7.7
Alcohol/drug abuse	13	9.4	44	7.8	10	4.1	67	7.1
Just like to move around	13	9.4	35	6.2	10	4.1	58	6.2
Government benefits stopped	7	5.0	18	3.2	2	0.8	27	2.9
Disaster	2	1.4	12	2.1	10	4.1	24	2.5
Deinstitutionalization	4	2.9	8	1.4	8	3.3	20	2.1
Was in jail/prison	2	1.4	9	1.6	4	1.7	15	1.6
No answer	0	0.0	12	2.1	1	0.4	13	1.4
Total	139	100.0	562	99.9	242	99.9	943	100.1

Transience

When comparing types of homelessness and number of places stayed during the past month, it was shown that Resource People are less mobile than the other two groups. Over 90 percent of Resource People have stayed in four or fewer places in the last month compared to 79.8 percent of Street People and 79.2 percent of Shelter People. This may be explained by the fact that shelters can be used for a limited time only. They are intended to be stop-gap measures, not permanent living arrangements. See Table T6.

Table T6

Number of Places Stayed During Past Month

NUMBER	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
1 - 2 places	85	61.1	286	50.9	165	68.2	536	56.8
3 - 4 places	26	18.7	159	28.3	54	22.3	239	25.3
5 - 6 places	10	7.2	45	8.0	8	3.3	63	6.7
7 - 8 places	2	1.4	12	2.1	6	2.5	20	2.1
More than 8 places	10	7.2	41	7.3	6	2.5	57	6.0
No answer	6	4.3	19	3.4	3	1.2	28	3.0
Total	139	99.9	562	100.0	242	100.0	943	99.9
Mean number of places	3.5		3.6		2.5		3.3	
Median number of places	2		2		2		2	

Of those contacted in this study, some 63.3 percent reported that they were either long-term (more than one year) residents or had always lived in the county where the interview was undertaken. People who have some resources and are homeless appeared to be somewhat more (45.9%) likely to have lived in the same county all their lives than either Street (41.7%) or Shelter (36.3%) People.

Those who were not indigenous to the county of interview were asked how long they had been in the county. Type of homelessness made some difference in the length of time these people had lived in the county. Street People (23.0%) and Shelter People (26.3%) were somewhat more likely than Resource People (16.5%) to have lived in the county less than a month. See Table T7.

Table T7

Length of Time in County

TIME	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Less than one week	12	8.6	75	13.3	10	4.1	97	10.3
1 - 4 weeks	20	14.4	73	13.0	30	12.4	123	13.0
1 - 6 months	10	7.2	44	7.8	20	8.3	74	7.8
7 - 12 months	8	5.7	22	3.9	15	6.2	45	4.8
More than one year	29	20.1	140	24.9	55	22.7	224	23.8
Permanent resident	58	41.7	204	36.3	111	45.9	373	39.6
No answer	2	1.4	4	0.7	1	0.4	7	0.7
Total	139	100.0	562	99.9	242	100.0	943	100.0

Subsequent questions determined where non-permanent-resident respondents had been before arriving in the county of interview. About one-third (33.9%) were from another Ohio county. When these 193 persons were included with the 373 indigenous Ohio homeless, it was discovered that 60 percent of the homeless sample in Ohio were from Ohio. When type of homelessness was accounted for, it was apparent that non-permanent-resident Resource People were more likely (41.2%) to be from Ohio than were Street (31.2%) or Shelter (31.8%) People. See Table T8.

Table T8

Where Non-Permanent-Resident Respondents Lived
Prior to Coming to this County

WHERE	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Another Ohio county	25	31.2	114	31.8	54	41.2	193	33.9
Pennsylvania	6	7.5	22	6.1	3	2.3	31	5.4
West Virginia	2	2.5	15	4.2	9	6.9	26	4.6
Kentucky	7	8.8	21	5.9	11	8.4	39	6.9
Indiana	2	2.5	11	3.1	3	2.3	16	2.8
Michigan	4	5.0	28	7.8	4	3.1	36	6.3
Other states	30	37.5	135	37.7	42	32.1	207	36.4
Other countries	0	0.0	3	0.7	1	0.7	4	0.7
No answer	4	5.0	9	2.5	4	3.1	17	3.0
Total	80	100.0	358	99.9	131	100.1	569	100.0

Analysis also examined respondents' reasons for coming to the county in which the interview took place. Only one finding highlighted differences in mobility due to type of homelessness. Resource People (45.0%) were much more likely to have relocated to be near friends or relatives than were Street (18.8%) or Shelter (20.1%) People. Even so, results showed that homeless people, regardless of type, sought attachments to others. See Table T9.

Table T9

Reason for Non-Permanent Residents Coming to County

REASON	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
To live with relative or friend	15	18.8	72	20.1	59	45.0	146	25.7
To look for a job	15	18.8	74	20.6	20	15.3	109	19.2
Other reasons	16	20.0	52	14.5	13	9.9	81	14.2
Just another stop while passing through	8	10.0	46	12.9	6	4.6	60	10.5
To take a job	11	13.8	22	6.2	17	13.0	50	8.8
For public sleeping shelters	3	3.8	25	7.0	3	2.3	31	5.4
Lived here before	6	7.5	20	4.5	6	4.6	32	5.6
For social service programs	0	0.0	7	2.0	1	0.8	8	1.4
To go to school	1	1.2	7	2.0	1	0.8	9	1.6
Heard you could get public welfare	0	0.0	4	1.1	1	0.8	5	0.9
For community kitchens	1	1.2	3	0.8	0	0.0	4	0.7
Less police hassle	0	0.0	1	0.3	1	0.8	2	0.4
No answer	4	5.0	25	7.0	3	2.2	32	5.6
Total	80	100.1	358	100.1	131	100.1	569	100.0

Employment and Income

In response to questions about their work history, 822 (87.2%) respondents indicated they had a job at some point in their life, including 232 (24.6%) who said they worked for pay in the past month. Of the Street People, 18.7 percent reported having worked in the last month, compared to 25.6 percent of Shelter People and 28.5 percent of Resource People. When asked the type of job held, only 25 percent indicated that their work was full-time permanent. Of these, however, Resource People (29.0%) were more likely to have held permanent, full-time jobs than Shelter People (25.6%), or Street People (11.5%). Street People (42.3%) were more likely to do day labor than Shelter People (37.2%), and Resource People (27.5%). See Table T10.

Table T10

Type of Work Done by Those Who Had Worked in the Past Month

TYPE	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Day labor	11	42.3	51	37.2	19	27.5	81	34.9
Permanent, full-time	3	11.5	35	25.6	20	29.0	58	25.0
Temporary job	7	26.9	32	23.4	17	24.6	56	24.1
Permanent, part-time	3	11.5	11	8.0	10	14.5	24	10.3
Other	2	7.7	8	5.8	2	2.9	12	5.2
No answer	0	0.0	0	0.0	1	1.4	1	0.4
Total	26	99.9	137	100.0	69	99.9	232	99.9

Street/Shelter. Resource People differed in the extent to which they had ever had a job. More Shelter People (91.8%), however, worked than Resource People (81.8%) or Street People (77.7%). Individuals who had worked in the past, but who were not now employed were asked in what year they last worked. Nearly two-thirds (62.5%) of the overall group had not worked for at least eighteen months, however the comparable percentage for Resource People was much lower (51.1%). See Table T11.

Table T11

Year Last Worked for Those Who Have Not Worked During the Past Month

YEAR	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
1983 - 1984	30	36.6	129	34.0	63	48.8	222	37.6
1978 - 1982	28	34.1	144	38.0	45	34.9	217	36.8
1969 - 1977	13	15.8	60	15.8	10	7.7	83	14.1
Prior to 1969	6	7.3	19	5.0	6	4.6	31	5.3
No answer	5	6.1	27	7.1	5	3.9	37	6.3
Total	82	99.9	379	99.9	129	99.9	590	100.1

Homeless people were asked why their last job ended. For the overall group, about 36.8 percent of the reasons were business-related (e.g., temporary work only, business closure, lay off), while 50.9 percent of the reasons were more individual-related (e.g., fired, quit, poor health, etc.). With only small variations, this general pattern was repeated for Street, Shelter, and Resource People. See Table T12.

Table T12

Reason of Formerly Employed Respondents for Last Job Ending

REASON	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Quit	16	19.5	58	15.3	28	21.7	102	17.3
Temporary job	18	22.0	65	17.2	13	10.1	96	16.3
Fired	10	12.2	54	14.3	22	17.1	86	14.6
Company closed/moved	8	9.8	39	10.3	14	10.9	61	10.3
Laid off	7	8.5	38	10.0	15	11.6	60	10.2
Other reasons	8	9.8	33	8.7	17	13.2	58	9.8
Poor physical health	7	8.5	41	10.8	9	7.0	57	9.7
Drinking/drugs	5	6.1	22	5.8	4	3.0	31	5.3
Poor mental health	1	1.2	12	3.2	2	1.6	15	2.5
Went to prison/jail	1	1.2	4	1.1	4	3.0	9	1.5
CETA benefits ended	0	0.0	2	0.5	0	0.0	2	0.3
No answer	1	1.2	11	2.9	1	0.8	13	2.2
Total	82	100.0	379	100.1	129	100.0	590	100.0

Overall, the major reason given by homeless people for not working now was their inability to find a job. This was equally true across the three types of homelessness. Being disabled was the second major reason for not working now as reported by respondents in each of the three types. However, Street People (26.8%) were more likely than Shelter People (20.6%) and Resource People (18.6%) to give "disability" as a reason. See Table T13.

Table T13

Reason of Formerly Employed Respondents
for Not Working Now

REASON	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Looked, but cannot find work	40	48.8	182	48.0	56	43.4	278	47.1
Disabled/cannot work	22	26.8	78	20.6	24	18.6	124	21.0
Other reasons	3	3.7	42	11.1	8	6.1	53	9.0
Plan to look for work	6	7.3	14	3.7	10	7.8	30	5.1
Do not want to work	5	6.1	16	4.2	7	5.4	28	4.7
Do not feel ready to work	3	3.7	17	4.5	9	7.0	29	4.9
To stay home with children	2	2.4	7	1.8	9	7.0	18	3.1
Alcohol/drug problem	0	0.0	8	2.1	0	0.0	8	1.4
Do not know where to look for work	1	1.2	5	1.3	2	1.6	8	1.4
Do not want to lose benefits	0	0.0	2	0.5	2	1.6	4	0.7
Do not need to work	0	0.0	3	0.8	0	0.0	3	0.5
Poor education	0	0.0	2	0.5	1	0.8	3	0.5
No answer	0	0.0	3	0.8	1	0.8	4	0.7
Total	82	100.0	379	99.9	129	100.1	590	100.1

Homeless people, to some extent, earn wages, but more likely, they receive some sort of public assistance or benefits. The availability and source of income was determined for the homeless population. Only about two-thirds (63.5%) reported receiving any income during the past month. Some differences existed for types of homelessness, however; Resource People (73.6%) were very likely to have received some income, as compared to Street (49.6%) or Shelter (62.6%) People.

There were differences between the three groups as to their major source of income. Resource People (41.8%) and Shelter People (38.1%) tended to receive welfare more frequently, while Street People reported welfare as their major financial resource less frequently (27.5%). See Table T14.

Table T14

Primary Income Source for Respondents Who Had Income
in the Past Month

SOURCE	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Welfare	19	27.5	134	38.1	74	41.8	227	38.0
Earnings	18	26.1	88	25.0	55	31.1	161	26.9
Social Security	16	23.2	75	21.3	26	14.7	117	19.6
Other sources	3	4.4	10	2.8	7	4.0	20	3.3
Family/friends	4	5.8	7	2.0	7	4.0	18	3.0
Refused to disclose	1	1.5	8	2.3	4	2.3	13	2.2
Pension	4	5.8	9	2.6	0	0.0	13	2.2
Charity	4	5.8	6	1.7	1	0.6	11	1.8
Mission/shelter work	0	0.0	8	2.3	0	0.0	8	1.3
Giving blood	0	0.0	6	1.7	3	1.6	9	1.5
No answer	0	0.0	1	0.3	0	0.0	1	0.2
Total	69	100.1	352	100.1	177	100.1	598	100.0

Social Service Usage

When homeless people were asked about their use of shelters, community mental health centers, soup kitchens, hospital emergency rooms, welfare or general relief, and shelters for battered women, several important differences were observed when type of homelessness was taken into account. Resource People responded somewhat differently from Street or Shelter People on two important items. Resource People (38.4%) were much less likely to receive meals from soup kitchens or food pantries than was the case for Street (61.9%) and Shelter (71.2%) People. By contrast, Resource People (52.1%) were much more likely to receive welfare than were Street (32.4%) and Shelter (44.5%) People. See Table T15.

Table T15

Social Service Usage

SOCIAL SERVICE	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Community kitchens	86	61.9	400	71.2	93	38.4	579	61.4
Shelters	0	0.0	551	100.0	0	0.0	551	58.4
Welfare/general relief	45	32.4	250	44.5	126	52.1	421	44.6
Hospital emergency rooms	23	16.6	161	28.7	45	18.6	229	24.3
Shelters for battered women	0	0.0	21	21.9	2	2.9	23	14.6
Community mental health centers	5	3.6	82	14.6	22	9.1	109	11.6

Obtaining food may be one of the most pressing needs of the homeless person, either because of their limited resources or the unavailability of public services. The availability of personal resources was clearly apparent in where and how homeless people in the three types obtained their food. For Street People and Shelter People, community kitchens were their major source of meals. Resource People were more likely to eat in a restaurant, buy food at a store and cook their own, or eat with friends than were either Shelter or Street People. See Table T16.

Table T16

Primary Source of Meals

PRIMARY FOOD SOURCE	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Community kitchen	63	45.3	304	54.1	52	21.5	419	44.4
Buy at store; cook one's own	18	12.9	75	13.3	65	26.9	158	16.8
Handouts	24	17.3	48	8.5	39	16.1	111	11.8
Restaurant	8	5.8	34	6.0	26	10.7	68	7.2
Family and friends	3	2.2	21	3.7	23	9.5	47	5.0
Other sources	3	2.2	25	4.4	10	4.1	38	4.0
Missions/shelters	1	0.7	29	5.2	0	0.0	30	3.2
Food pantry; cook one's own	2	1.4	8	1.4	14	5.8	24	2.6
Do without	10	7.2	7	1.3	9	3.7	26	2.8
Dumpsters, trash	6	4.3	7	1.3	1	0.4	14	1.5
Vending machines	0	0.0	1	0.2	1	0.4	2	0.2
Stealing	1	0.7	1	0.2	0	0.0	2	0.2
No answer	0	0.0	2	0.4	2	0.8	4	0.4
Total	139	100.0	562	100.0	242	99.9	943	100.1

Psychiatric Hospitalization

Respondents were asked if they had ever been hospitalized for a mental or emotional problem. Results showed that slightly less than one-third (28.8%) reported being hospitalized.

Among those who had been hospitalized, some differences were observed among types of homelessness. Resource People (20.7%) were somewhat less likely to have been hospitalized than were Street (27.3%) and Shelter (32.7%) People.

Differences were also found in the types of hospitals where these homeless people received psychiatric treatment. Shelter People (20.5%) were more likely to have been in state psychiatric hospitals than Street People (12.2%) or Resource People (12.8%). However, Street People (7.9%) and Shelter People (7.5%) were more likely to have been in a veteran's hospitals than Resource People (2.1%). See Table T17.

Table T17

Psychiatric Hospitalization

HOSPITALIZATION	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Never been hospitalized	96	69.1	375	66.7	188	77.7	659	69.9
Been hospitalized	38	27.3	184	32.7	50	20.7	272	28.8
(Veteran's hospital)	(11)	(7.9)	(42)	(7.5)	(5)	(2.1)	(58)	(6.2)
(General hospital)	(16)	(11.5)	(78)	(13.9)	(26)	(10.7)	(120)	(12.7)
(State hospital)	(17)	(12.2)	(115)	(20.5)	(31)	(12.8)	(163)	(17.3)
No answer	5	3.6	3	0.5	4	1.7	12	1.3
Total	139	100.0	562	99.9	242	100.1	943	100.0

* Hospitalized subtotals do not add to percentages hospitalized because some respondents have had hospitalizations in more than one type of setting.

Of those 163 persons who had been hospitalized in a state psychiatric hospital, 38.6 percent were hospitalized once. This percentage varied little across the three types of homeless persons, and the median number of hospitalizations for all three types was two. See Table T18.

Table T18

Number of Times Hospitalized for Those Ever Hospitalized in a State Psychiatric Facility

TIMES HOSPITALIZED	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
one	7	41.2	45	39.1	11	35.5	63	38.7
two	2	11.8	20	17.4	4	12.9	26	16.0
3 - 4	1	5.9	19	16.5	6	19.4	26	16.0
5 - 6	2	11.8	12	10.4	3	9.7	17	10.4
7 or more	3	17.6	12	10.4	3	9.7	18	11.0
No answer	2	11.8	7	6.1	4	12.9	13	8.0
Total	17	100.1	115	99.9	31	100.1	163	100.1
Mean number of times	4.5		3.7		3.1		3.7	
Median number of times	2		2		2		2	

Table T19 shows the year in which homeless people were last released from a state hospital. When types of homelessness were included for analysis, results became difficult to interpret because of small sample sizes, especially among the Street and Resource People. In spite of this limitation, one conclusion appeared to be that a higher percentage of Resource People had been released from psychiatric hospitals in the last three and one-half years than Street or Shelter People.

Table T19

Year Last Released for Those Ever Hospitalized in a State Psychiatric Hospital

YEAR	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
1984 - 1983	6	35.3	50	43.5	19	61.3	75	46.0
1982 - 1981	1	5.9	17	14.8	5	16.1	23	14.1
1980 - 1979	2	11.8	8	7.0	3	9.7	13	8.0
1978 - 1970	3	17.6	20	17.3	1	3.2	24	14.7
1969 or before	0	0.0	11	9.7	2	6.4	13	8.0
No answer	5	29.4	9	7.8	1	3.2	15	9.2
Total	17	100.0	115	100.1	31	99.9	163	100.0

Those reporting that they were patients in state psychiatric hospitals were asked whether or not living arrangements were made for them at the time of their release.

Because of the relatively small number of cases in the Street and Resource People samples, inferences about release were not possible. For Shelter People, however, nearly two-fifths (40.4%) reported that no arrangements were made for them to be released in a suitable environment.

Those people for whom arrangements were made (N=96) were asked whether or not they had showed up at the designated site of release. Eighty-three people indicated that they had shown up. The remaining thirteen people (13.6%) had not. Street People were less likely (75.0%) to show up than either Shelter (87.3%) or Resource (90.5%) People. See Table T20.

Table T20

Reported Living Arrangements for Respondents Released from State Hospitalization

RELEASED TO	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
No arrangements were made	4	23.5	46	40.0	8	25.8	58	35.6
Family	4	23.5	22	19.1	10	32.3	36	22.1
Other arrangements	0	0.0	15	13.0	3	9.7	18	11.0
Own apartment or house	4	23.5	13	11.3	1	3.2	18	11.0
Group home	4	23.5	11	9.6	2	6.5	17	10.4
Hotel/motel	0	0.0	2	1.7	5	16.1	7	4.3
No answer	1	5.9	6	5.2	2	6.5	9	5.5
Total	17	99.9	115	99.9	31	101.1	163	99.9
Arrangements were made (N=96)								
Went to place arranged for them (N=83)	9	75.0	55	87.3	19	90.5	83	86.4

Referral and Contact with a CMHC. Community mental health centers are expected to offer aftercare services to individuals who no longer receive treatment from state psychiatric hospitals. The referral procedure which links the patient from the state hospital to the CMHC is, therefore, important in insuring that patients receive the treatment they require. Homeless people in the study who had been in a state hospital were asked whether or not they had been referred to a CMHC. Only one-half (52.5%) reported having been referred. This finding was consistent across the three types of homelessness.

Of the 85 persons who were referred to a CMHC, over one-half (57.6%) stated that they had contacted a CMHC, while only 10.6 percent were contacted by the CMHC. This indicated that nearly one-fourth (28.2%) had no contact at all with a CMHC. Resource People are more likely to initiate contact (68.7%) than are Street People (55.6%), or Shelter People (55.0%). See Table T21.

Table T21

Contact with a Community Mental Health Center
for Those Referred

TYPE OF CONTACT	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
I contacted them	5	55.6	33	55.0	11	68.8	49	57.6
They contacted me	1	11.1	7	11.7	1	6.2	9	10.6
No contact	2	22.2	19	31.7	3	18.7	24	28.2
No answer	1	11.1	1	1.7	1	6.3	3	3.5
Total	9	100.0	60	100.1	16	100.0	85	99.9

When asked about returning to a state psychiatric hospital, 40.5 percent of the overall group indicated that they would like to return or would not mind returning to a hospital. More than one-half (52.8%), however, would not like to return. More Shelter (55.7%) and Resource (51.6%) People would not want to go back than Street People (35.3%). See Table T22.

Table T22

Feelings about Returning to a State Hospital
by Those Ever Hospitalized

FEELINGS	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Not want to go back	6	35.3	64	55.7	16	51.6	86	52.8
Not mind going back	7	41.2	27	23.5	11	35.5	45	27.6
Like to go back	3	17.7	15	13.0	3	9.7	21	12.9
Not thought about it	1	5.9	5	4.3	1	3.2	7	4.3
Would go back for shelter	0	0.0	1	0.9	0	0.0	1	0.6
No answer	0	0.0	3	2.6	0	0.0	3	1.8
Total	17	100.1	115	100.0	31	100.0	163	100.0

Social Network

A few slight differences were noted between the three groups and their feelings about having relatives they can count on for help. Street People were less likely (27.3%) to say that they have relatives they can count on for help than Shelter People (36.5%) and Resource People (39.7%), and Street People were more likely (28.8%) to say that they do not have any relatives than Shelter People (18.7%) and Resource People (17.8%). See Table T23.

Table T23

"Do you have any relatives you can count on for help?"

RESPONSE	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Yes	38	27.3	205	36.5	96	39.7	339	35.9
No, can't count on	56	40.3	249	44.3	100	41.3	405	42.9
No, no relatives	40	28.8	105	18.7	43	17.8	188	19.9
No answer	5	3.6	3	0.5	3	1.2	11	1.2
Total	139	100.0	562	100.0	242	100.0	943	99.9

For those respondents who have relatives, differences were noted between the three groups and the amount of time since contact with their relatives. As many as 61.2 percent of the Resource People had had contact with relatives within the past week compared to only 37.2 percent of the Street People and 34.6 percent of the Shelter People. See Table T24.

Table T24

Time Since Contact with Relatives
for Those Who Have Relatives

DAYS	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
1 - 7	35	37.2	157	34.6	120	61.2	312	41.9
8 - 30	20	21.3	95	20.9	24	12.2	139	18.7
31 - 90	9	9.6	55	12.1	20	10.2	84	11.3
91 - 180	5	5.3	33	7.3	3	1.5	41	5.5
181 - 365	5	5.3	31	6.8	10	5.1	46	6.2
366 or more	16	17.0	61	13.4	13	6.6	90	12.1
No answer	4	4.3	22	4.8	6	3.1	32	4.3
Total	94	100.0	454	99.9	196	100.0	744	100.0
Mean number of days	458.2		281.1		169.1		286.3	
Median number of days	14		21		3		14	

Overall, the major reasons for infrequent contact with relatives were: "no desire to maintain the relationship" (23.4%) and "relatives don't live nearby" (21.1%). No apparent differences were noted between the three different homeless types. See Table T25.

Table T25

Reasons for Infrequent Contact with Relatives
for Those Who Have Not Had Contact for More Than One Month

REASONS	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
No desire to maintain relationship	11	31.4	41	22.8	9	19.6	61	23.4
Relatives do not want to see me	6	17.1	36	20.0	9	19.6	51	19.5
Relatives do not live nearby	5	14.3	42	23.3	8	17.4	55	21.1
They would not help	8	22.9	17	9.4	9	19.6	34	13.0
Other reasons	0	0.0	19	10.6	1	2.2	20	7.7
I'm ashamed of current situation	1	2.9	7	3.8	4	8.7	12	4.6
It has been too long since I've seen them	3	8.6	5	2.8	2	4.3	10	3.8
Do not know where they are	0	0.0	4	2.3	0	0.0	4	1.5
They cannot help me/ they need help too	0	0.0	3	1.6	0	0.0	3	1.1
No transportation	0	0.0	0	0.0	1	2.2	1	0.4
No answer	1	2.9	6	3.3	3	6.5	10	3.8
Total	35	100.1	180	99.9	46	100.1	261	99.9

Street People are less likely (32.4%) to report that they have friends they can count on for help than are Shelter (39.5%) or Resource People (48.3%). Also Street People are more likely (36.7%) to say they do not have any friends than are Shelter People (28.1%) or Resource People (19.0%). See Table T26.

Table T26

"Do you have any friends you can count on for help?"

RESPONSE	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Yes	45	32.4	222	39.5	117	48.3	384	40.7
No, can't count on	42	30.2	180	32.0	73	30.2	295	31.3
No, no friends	51	36.7	158	28.1	46	19.0	255	27.0
No answer	1	0.7	2	0.4	6	2.5	9	0.9
Total	139	100.0	562	100.0	242	100.0	943	99.9

Over one-half (54.5%) of the respondents who indicated they had friends thought they had enough close friends. This was equally true when type of homelessness was taken into account. See Table T27.

Table T27

"Do you have enough close friends?"

RESPONSE	STREET Number	STREET %	SHELTER Number	SHELTER %	RESOURCE Number	RESOURCE %	TOTAL Number	TOTAL %
Yes	52	59.8	213	53.1	105	55.0	370	54.5
No	34	39.1	179	44.6	85	44.5	298	43.9
No answer	1	1.1	9	2.2	1	0.5	11	1.6
Total	87	100.0	401	99.9	191	100.0	679	100.0

Overall, 71.1 percent of the three types of homeless respondents had had contact with friends in the last week, however, more Street People (80.5%) and Resource People (79.1%) had seen friends in the last week than Shelter People (65.3%). See Table T28.

Table T28

Time Since Contact with Friends
for Those Who Have Friends

DAYS	STREET Number	STREET %	SHELTER Number	SHELTER %	RESOURCE Number	RESOURCE %	TOTAL Number	TOTAL %
1 - 7	70	80.5	262	65.3	151	79.1	483	71.1
8 - 30	7	8.0	42	10.5	15	7.3	64	9.4
31 - 90	1	1.1	17	4.2	10	5.2	28	4.1
91 - 180	1	1.1	14	3.5	2	1.0	17	2.5
181 - 365	2	2.3	11	2.7	5	2.6	18	2.7
366 or more	3	3.5	17	4.2	3	1.6	23	3.4
No answer	3	3.5	38	9.5	5	2.6	46	6.8
Total	87	99.9	401	99.9	191	99.9	679	100.0
Mean number of days	39.3		110.8		48.6		83.1	
Median number of days	1		2		1		1	

Physical Health Problems

Overall, 30.7 percent of the respondents indicated they had a physical problem which should be treated by a physician. Resource People (21.9%), however, reported having fewer problems than either Shelter (33.3%) or Street (36.0%) People. Only in the case of ill-defined conditions among Street People, were results very different for the three types of homelessness. See Table T29.

Table T29

Physical Health Problems

PROBLEM	STREET No.	 %	SHELTER No.	 %	RESOURCE No.	 %	TOTAL No.	 %
Reported no physical problems	86	61.9	372	66.2	187	77.3	645	68.4
Reported physical problems	50	36.0	187	33.3	53	21.9	290	30.8
Ill-defined conditions	(24)	(17.3)	(49)	(8.7)	(13)	(5.4)	(86)	(9.1)
Arthritis, rheumatism and other diseases of the musculo-skeletal system	(9)	(6.5)	(32)	(5.7)	(7)	(2.9)	(48)	(5.1)
Injury and poisoning	(6)	(4.3)	(26)	(4.6)	(9)	(3.7)	(41)	(4.3)
Diseases of the heart and circulatory system	(5)	(3.6)	(27)	(4.8)	(6)	(2.5)	(38)	(4.0)
Diseases of the nervous system and sense organs	(1)	(0.7)	(28)	(5.0)	(4)	1.6)	(33)	(3.5)
Diseases of the respiratory system	(7)	(5.0)	(17)	(3.0)	(3)	(1.2)	(27)	(2.9)
Diseases of the digestive system	(7)	(5.0)	(15)	(2.7)	(4)	(1.6)	(26)	(2.7)
Eye problems	(6)	(4.3)	(15)	(2.7)	(1)	(0.4)	(22)	(2.3)
Endocrine and nutritional disorders	(3)	(2.1)	(10)	(1.8)	(5)	(2.1)	(18)	(1.9)
Dental problems	(0)	(0.0)	(10)	(1.8)	(5)	(2.1)	(15)	(1.6)
Infections and parasitic disorders	(2)	(1.4)	(7)	(1.2)	(2)	(0.8)	(11)	(1.2)
Neoplasms (cancer and benign tumors)	(1)	(0.7)	(5)	(0.9)	(4)	(1.6)	(10)	(1.1)
Diseases of the genito-urinary system	(2)	(1.4)	(5)	(0.9)	(2)	(0.8)	(9)	(0.9)
Pregnancy	(1)	(0.7)	(4)	(0.7)	(4)	(1.6)	(9)	(0.9)
Diseases of the blood	(0)	(0.0)	(4)	(0.7)	(3)	(1.2)	(7)	(0.7)
Alcoholism	(0)	(0.0)	(5)	(0.9)	(1)	(0.4)	(6)	(0.6)
Diseases of the skin	(0)	(0.0)	(3)	(0.5)	(0)	(0.0)	(3)	(0.3)
No answer	(0)	(0.0)	(2)	(0.3)	(0)	(0.0)	(2)	(0.2)
No answer	3	2.2	3	0.5	2	0.8	8	0.8
Total	139	100.0	562	100.0	242	100.0	943	100.0

Note: Subtotals for types of problems do not add to percents reporting problems because some respondents indicated they had two problems.

Homeless people were asked about taking drugs or medications during the past month. Only one-third (31.4%) reported that they had. Shelter (35.0%) People were more likely to have taken drugs than were Street (22.3%) or Resource (28.1%) People. Importantly, drugs taken were indicated as having been prescribed by physicians for some 69.3 percent of those admitting to drug consumption. No differences across the three types of homelessness were noted.

Only a small percentage (15.4%) reported that drugs consumed had caused them any problems. No differences were noted across the three types of homeless persons. See Table T30.

Table T30

Usage of Drugs and Medications within the Past Month

USAGE CATEGORY	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Use drugs or medications (N=943)								
Yes	31	22.3	197	35.0	68	28.1	296	31.4
No	106	76.3	363	64.6	173	71.5	642	68.1
No answer	2	1.4	2	0.4	1	0.4	5	0.5
Total	139	100.0	562	100.0	242	100.0	943	100.0
If used drugs/medications (N=296)								
A. Drugs/medications are prescribed								
Yes	20	64.5	138	70.0	47	69.1	205	69.3
No	8	25.8	46	23.3	20	29.4	74	25.0
Some were; some weren't	2	6.4	12	6.1	1	1.5	15	5.1
No answer	1	3.2	1	0.5	0	0.0	2	0.7
Total	31	99.9	197	99.9	68	100.0	296	100.1
B. Trouble with drugs/medications								
Yes	4	12.9	30	15.2	9	13.2	43	14.5
No	25	80.6	156	79.2	54	79.4	235	79.4
No answer	2	6.5	11	5.6	5	7.3	18	6.1
Total	31	100.0	197	100.0	68	99.9	296	100.0

Next, homeless people were asked about alcohol abuse. Nearly one-half (46.1%) reported drinking some and another one-fifth (19.2%) reported drinking a lot during the past month. Street (24.5%) and Shelter (21.4%) People reported drinking "a lot" more often than Resource People (11.2%). See Table T31.

Table T31

Reported Drinking During the Past Month

AMOUNT OF DRINKING	STREET Number	STREET %	SHELTER Number	SHELTER %	RESOURCE Number	RESOURCE %	TOTAL Number	TOTAL %
Some	73	52.5	233	41.5	129	53.3	435	46.1
A lot	34	24.5	120	21.4	27	11.2	181	19.2
Not at all	31	22.3	207	36.8	84	34.7	322	34.1
No answer	1	0.7	2	0.4	2	0.8	5	0.5
Total	139	100.0	562	100.1	242	100.0	943	99.9

When asked whether or not they had sought help for a drinking problem, 26 percent across the three homeless types reported that they had. However, more Street (25.9%) and Shelter (31.8%) People indicated that they have sought help than did Resource People (12.4%). See Table T32.

Table T32

Seeking Help for Drinking

BEHAVIOR	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Have ever sought help	36	25.9	179	31.8	30	12.4	245	26.0
Have not sought help	99	71.3	364	64.8	209	86.4	672	71.3
No answer	4	2.9	19	3.4	3	1.2	26	2.8
Total	139	100.0	562	100.0	242	100.0	943	100.1

General Well-being

Overall, 40.5 percent of respondents reported that their nerves, spirits, outlook or mental health at present was either good or excellent. Patterns of response were similar across type of homeless condition. See Table T33.

Table T33

"How would you rate your nerves, spirits, outlook, or mental health at present?"

RESPONSE	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Excellent	10	7.2	64	11.4	14	5.8	88	9.3
Good	39	28.1	178	31.7	77	31.8	294	31.2
Fair	45	32.4	186	33.1	95	39.3	326	34.6
Poor	26	18.7	88	15.1	31	12.8	145	15.4
Very bad	15	10.8	39	6.9	19	7.8	73	7.7
No answer	4	2.9	7	1.2	6	2.5	17	1.8
Total	139	100.1	562	100.0	242	100.0	943	100.0

Overall, 33.8 percent reported that, in general, their life was very or somewhat satisfying. No striking differences were noted when type of homelessness was taken into account. See Table T34.

Table T34

"In general, how satisfying would you say your life has been?"

RESPONSE	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
Very satisfying	9	6.5	70	12.5	15	6.2	94	10.0
Somewhat satisfying	36	25.9	127	22.6	61	25.2	224	23.8
Mixed	45	32.4	209	37.2	98	40.5	352	37.3
Not very satisfying	37	26.6	102	18.0	46	19.0	185	19.6
Not at all satisfying	7	5.0	47	8.6	19	7.8	73	7.7
No answer	5	3.6	7	1.1	3	1.2	15	1.6
Total	139	100.0	562	100.0	242	99.9	943	100.0

These results would seem to indicate that a surprisingly large percentage of homeless people rate their general well-being as relatively good, despite their circumstances. However, comparative data on these same two items from two samples of 2,183 people in five rural southern Ohio counties (see Tables S33 and S34 in the Statewide Results chapter) indicate that the general population rates its mental health as being substantially better than does the homeless population.

MENTAL HEALTH STATUS RESULTS

Our discussion of the mental health status of homeless people is essentially organized around four analysis efforts. The first effort focuses specifically on each of the ten symptom dimensions we measured. Distributional characteristics of the symptom areas are presented in some detail. Also, these distributions are reorganized into clinical severity distributions through the use of cut-off scores. Next, we discuss our effort to meaningfully combine these symptom scales into two severity indices that attempt to capture the multiple-symptom nature of psychiatric diagnosis. Third, the symptomatology of our respondents is compared to two other respondent groups, newly admitted inpatients and transitional services clients who had successfully lived in the community for one year. Finally, we examined the relationship between the Psychiatric Status Schedule (PSS) scales and other homeless person characteristics in an attempt to identify how types of experiences, conditions or resources relate to mental health status. Urban-rural differences and types of homelessness differences on mental health status are addressed specifically in separate sections and a final section is concerned with identifying correlates to psychiatric problems of homeless people.

Distribution of Psychiatric Symptoms

This section presents the distributional characteristics of our homeless respondent group along the ten symptom dimensions we measured. We have presented both the raw score frequency distribution of each scale and a distribution of clinical severity levels for each scale based on cut-off scores suggested by PSS researchers.

Before discussing the symptom areas, two terms should be clarified that might be unfamiliar to the reader. The first term, "skewed" or "skewness", is used to describe the shape of each distribution. Distribution shape is an important concept to portray in the analysis of data, and the index of skewness was developed to assess one component of that shape. A distribution can be either positively or negatively skewed. A positively skewed distribution is one where the bulk of cases is located at the low end of the measurement scale with the number of cases decreasing as the scores increase. A negatively skewed distribution is the opposite, where the bulk of cases occurs at the high end of the measurement scale and the number of cases decreases as scores get smaller. In our presentation, distribution shape conveys special meaning about psychiatric symptoms, hence the need to use the concept of skewness to represent that shape.

The second term, "cut-off scores", refers to points on a scale which establish meaningful divisions between areas of a continuum. In the mental health area, these cut-off points can be used to make decisions about classifying cases. The scores are established by administering scales to large numbers of people who experience a range of disorders and then by determining which score values correspond to levels of severity, types of problems, or the like. On our symptom scales, for example, cut-off scores have been established that permit the classification of cases on the basis of three levels of clinical severity. The cut-off scores discussed in this section were developed by the same team of clinician-researchers who constructed the PSS.

Depression-Anxiety. The Depression-Anxiety scale is composed of 38 items and is constructed through a simple weighting/summing procedure. The scale is a measure of "subjective feelings and concerns and psychophysiological dysfunctions that may be associated with the depressive, anxious, phobic or obsessive-compulsive syndromes" (Spitzer, et al., 1970, p. 44). The potential scale range is from 0 (no true items) to 38 (every item true), with a higher score indicating more serious symptomatology. A depressed or anxious respondent would be one who has, for example, trouble sleeping, little interest in activities, many fears, poor appetite, poor concentration, feelings of being inadequate, or other such thoughts or behaviors.

Table MHS1 presents the distribution of scores obtained from our homeless respondents on this scale. The range of scores is from 0 to 31; the mean of the distribution is 8.4 (median = 7, mode = 4), and the standard deviation is 6.3. The distribution shape is slightly skewed in the positive direction, where positive refers to the fact that the distribution tends to narrow as the scores increase.

Table MHS1

Depression-Anxiety Frequency Distribution

```
Scores                                                   #
  31 .  *                                                3
     .  **                                               5
     .  **                                               7
  25 .  ****                                            14
     .  ****                                            15
     .  ******                                          24
  19 .  ********                                        29
     .  *********                                       33
     .  *************                                   51
  13 .  **********************                          85
     .  **********************                          85
     .  ***************************                    105
   7 .  *********************************              132
     .  ****************************************       158
     .  *********************************              130
   0 .  **************************                     103
        ----+----+----+----+----+----+----+----+
        * MAY REPRESENT UP TO 4 COUNTS
```

The data presented in Table MHS2, however, are more helpful in understanding the above information. This frequency distribution is the same information recast into categories of clinical severity. These data indicate that 41.4 percent of our respondents have at least mild depressive-anxious concerns and that, if moderate and above is considered the cutting point, 18.4 percent of our respondents have scores which correspond to the presence of thoughts or behaviors that negatively affect an individual's capacity to function.

Table MHS2

Depression-Anxiety Clinical Severity Distribution

CATEGORY	Number	%
Extreme	20	2.0
Severe	62	6.3
Moderate	99	10.1
Mild	225	23.0
Minimal	182	18.6
None	391	39.9
Total	979	99.9

Suicide-Self-mutilation. The Suicide-Self-mutilation scale is composed of seven items and is a measure of "suicidal thoughts, preoccupation, threats, gestures or attempts, and thoughts or acts of self-mutilation" (Spitzer, et al., 1970, p. 44). This scale is our principal measure of the "dangerousness to self" tendencies of respondents. To be considered dangerous to one's self, a respondent would demonstrate suicidal thoughts or intent or might, in fact, report an effort to commit suicide. All of the items composing the scale are equally weighted so the potential scale range is 0 (no true items) to 7 (every item true), with a higher score indicating more serious psychopathology.

Table MHS3 presents the raw score distribution of this variable obtained from our respondents. The range of scores is from 0 to 7; the mean is .48 (median = 0, mode = 0), and the standard deviation is 1.14. The shape of this distribution is notable because it is highly positively skewed, with the preponderance of respondents having scores of zero.

Table MHS3

Suicide - Self-mutilation Frequency Distribution

```
Scores                                              #
   7 . *                                            3
     .
     . *                                            5
     .
     . *                                           11
     .
     . *                                           16
   3 .
     . ***                                         39
     .
     . ****                                        54
     .
     . *****                                       74
     .
   0 . **********************************************777
       ----+----+----+----+----+----+----+----+----+-
       * MAY REPRESENT UP TO 17 COUNTS
```

Table MHS4 contains the recategorization of the Suicide-Self-mutilation distribution into clinical severity categories. It can be seen that the bulk of respondents, nearly 87 percent, reported no indicators of problems in this area, and 3.5 percent demonstrated the presence of behaviors or thoughts that correspond to serious problems in this area.

Table MHS4

Suicide - Self-mutilation Clinical Severity Distribution

CATEGORY	Number	%
Extreme	3	0.3
Severe	16	1.6
Moderate	16	1.6
Mild	39	4.0
Minimal	54	5.5
None	851	86.9
Total	979	99.9

Speech Disorganization. The Speech Disorganization scale is composed of thirteen items, a number of which are also differentially weighted to reflect the relative importance of an item. This scale focuses on speech impairment and has a potential range of 0 (no true items) to 29 (every item true). A speech-disorganized person would, for example, ramble in conversation, have loose associations, or might be occasionally incoherent.

Table MHS5 presents the raw scores of our respondents on this variable. The range of scores is from 0 to 26, with the mean being 2.25 (median = 0, mode = 0), and the standard deviation being 4.01. The shape of this variable is highly positively skewed, with very few cases having higher scores.

Table MHS5

Speech Disorganization Frequency Distribution

```
Scores                                                       #
  26 .  *                                                    1
     .
     .  *                                                    2
     .
     .  *                                                    1
     .  *                                                    1
     .  *                                                    2
     .  *                                                    4
     .  *                                                    1
     .  *                                                    4
     .  *                                                    4
     .  *                                                    5
     .  *                                                    5
  13 .  *                                                    6
     .  *                                                    4
     .  *                                                    7
     .  *                                                   13
     .  **                                                  22
     .  **                                                  16
     .  **                                                  26
     .  ***                                                 28
     .  ***                                                 27
     .  ****                                                52
     .  *****                                               59
     .  ***                                                 37
     .  ******                                              71
   0 .  *********************************************581
        ----+----+----+----+----+----+----+----+---
        * MAY REPRESENT UP TO 13 COUNTS
```

Table MHS6 presents the clinical severity distribution of Speech Disorganization. About 70 percent of our respondents did not manifest a significant degree of impairment on this variable. The remaining 30 percent scored moderate or above, with about 4 percent indicating extreme problems in this area.

Table MHS6

Speech Disorganization Clinical Severity Distribution

CATEGORY	Number	%
Extreme	36	3.7
Severe	116	11.8
Moderate	138	14.1
Mild	37	3.8
None or Minimal	652	66.6
Total	979	100.0

Inappropriate Affect, Appearance or Behavior. This scale is composed of ten items and is concerned with the "appearance, physical acts or behaviors which would be considered odd or inappropriate by most untrained persons" (Spitzer, et al., 1970, p. 44). This domain was included in the study as one measure of the extent to which homeless people, by their actions or behavior, draw attention to themselves in a negative way. The types of behaviors or characteristics the scale measures include, for example, dirty or bizarre clothes, inappropriate laughter, talking to one's self, inappropriate sexual advances and the like. The scale also uses a weighting scheme to indicate the relative clinical importance of each item and has a potential range from 0 (no true items) to 19 (all items true).

Table MHS7 presents the raw scores obtained from our respondents. The range of scores is from 0 to 16; the mean is 1.76 (median = 1, mode = 0), and the standard deviation is 2.30. Again, the distribution shape is a reverse J, which indicates a high degree of positive skewness and reflects the fact that higher scores on this scale are fairly rare.

Table MHS7

Inappropriate Affect, Appearance or Behavior
Frequency Distribution

```
Scores                                                 #
 16 .  *                                               1
    .
    .  *                                               1
    .
    .  *                                               3
    .  *                                               3
    .  *                                               5
    .  **                                             10
  8 .  **                                             16
    .  **                                             10
    .  ***                                            20
    .  *****                                          37
    .  *******                                        55
    .  *********                                      79
    .  ********************                          173
    .  ********************                          174
  0 .  ****************************************** 392
       ----+----+----+----+----+----+----+----+--
       * MAY REPRESENT UP TO 9 COUNTS
```

Table MHS8 displays the recategorization of the scale into clinical severity categories. Almost 76 percent of our respondents had scores which correspond to the none, minimal or mild categories. Scores in the moderate to extreme categories, the remaining 24 percent, correspond to the presence of behaviors or characteristics that would likely be attention getting, such as being dirty and acting inappropriately.

Table MHS8

Inappropriate Affect, Appearance or Behavior
Clinical Severity Distribution

CATEGORY	Number	%
Extreme	49	5.0
Severe	112	11.4
Moderate	79	8.0
Mild	173	17.7
None or Minimal	566	57.8
Total	979	99.9

Interview Belligerence-Negativism. This 16-item scale focused on the belligerent or negative behaviors demonstrated by a respondent through the interview session. It assessed, for example, refusal to cooperate, sarcasm, argumentativeness or other distracting, possibly aggressive, actions. The scale also uses a weighting scheme to indicate the clinical importance of an item and has a potential range of 0 (no items true) to 21 (every item true).

Table MHS9 presents the raw scores obtained from our respondents. The range of scores is from 0 to 16; the mean is .99 (median = 0, mode = 0), and the standard deviation is 2.27. The distribution is also positively skewed in shape.

Table MHS9

Interview Belligerence-Negativism Frequency Distribution

```
Scores                                                  #
  16 .  *                                               1
     .  *                                               1
     .  *                                               3
     .  *                                               3
     .  *                                               3
     .  *                                               3
     .  *                                               6
     .  *                                               4
   8 .  *                                               1
     .  *                                              11
     .  **                                             18
     .  **                                             20
     .  **                                             24
     .  **                                             25
     .  *****                                          65
     .  *******                                       103
   0 .  *******************************************688
        ----+----+----+----+----+----+----+----+---
        * MAY REPRESENT UP TO 15 COUNTS
```

Cut-off scores for Interview Belligerence-Negativism were not available, so the information has not been measured in terms of its clinical severity. A few comments about this variable can be made, however. First, 81 percent of our respondents had a raw score of one or less, indicating that, in general, interviewers were not confronted with substantial amounts of non-cooperative or aggressive behavior. It was also the case that interviewers reported having very little difficulty engaging homeless respondents in discussion, and when respondents were non-cooperative it was not in an aggressive or hostile manner.

Disorientation-Memory Impairment. This scale is designed to measure "visible signs of disorientation to time, place, and persons, and impairment in recent or remote memory" (Spitzer, et al., 1970, p. 44). The scale is composed of eleven items, some of which are weighted to reflect relative clinical importance. It has a potential range of 0 (no items true) to 26 (every item true), and was included in the study as a measure of potential organicity. A respondent having problems in this symptom area might, for example, forget certain things about his/her life, not be oriented as to time or place, or have trouble following interview questions.

Table MHS10 presents the raw score distribution of scores on this scale. The range of scores is from 0 to 16; the mean is .91 (median =0, mode = 0), and the standard deviation is 2.05. The distribution is also positively skewed.

Table MHS10

Disorientation - Memory Impairment Frequency Distribution

```
Scores                                                #
  16 .  *                                             1
     .
     .
     .  *                                             2
     .  *                                             2
     .  *                                             4
     .  *                                             3
     .  *                                             3
   8 .  *                                             6
     .  *                                            10
     .  **                                           22
     .  *                                             7
     .  **                                           28
     .  *****                                        64
     .  *                                            11
     .  ********                                    117
   0 .  *******************************************699
        ----+----+----+----+----+----+----+----+---
        * MAY REPRESENT UP TO 15 COUNTS
```

Table MHS11 presents the Disorientation-Memory Impairment scale in clinical severity categories. This distribution shows that almost 85 percent of our respondents demonstrated no, minimal or mild severity on the scale. The remaining 15 percent have scores that correspond to the presence of characteristics that are sufficiently severe to reduce functioning capacity.

Table MHS11

Disorientation - Memory Impairment
Clinical Severity Distribution

CATEGORY	Number	%
Extreme	12	1.2
Severe	48	4.9
Moderate	92	9.4
Mild	11	1.1
None or Minimal	816	83.4
Total	979	100.0

Retardation-Lack of Emotion. This 15-item scale focuses on "visible signs of retardation in speech and movement, a tendency to ignore the surroundings, and flattening of affect or a general lack of emotional expression" (Spitzer, et al., 1970, p. 44). It is very important to note that retardation does not refer to mental retardation or reduced mental capacity, rather in this instance it refers to a slowing or dulling of the respondent's speech or movement. The scale also has a weighting scheme to indicate the clinical importance of various items and has a potential range of 0 (no true items) to 22 (all items true). A respondent having problems in this area might, for example, appear emotionless, be passive, give few or no answers to questions or answer slowly and faintly, or appear preoccupied and unresponsive.

Table MHS12 presents the raw score distribution of scores on this scale. The range of scores is from 0 to 18; the mean is 2.92 (median = 1, mode = 0), and the standard deviation is 3.64. The distribution is fairly positively skewed, although less so than most of the other scales.

Table MHS12

Retardation - Lack of Emotion Frequency Distribution

```
Scores                                                      #
  18 .  *                                                   1
     .  *                                                   1
     .  *                                                   6
     .  *                                                   4
     .  *                                                   5
     .  **                                                 10
     .  **                                                 13
     .  **                                                 11
     .  **                                                 14
   9 .  ***                                                24
     .  ****                                               30
     .  *****                                              35
     .  ********                                           59
     .  *******                                            53
     .  ******                                             47
     .  **********                                         75
     .  **************                                    100
     .  ****************                                  118
   0 .  ***********************************************373
        ----+----+----+----+----+----+----+----+---
        * MAY REPRESENT UP TO 8 COUNTS
```

Table MHS13 presents the scores recategorized into levels of clinical severity. Scores on this variable tend to indicate the presence of more problems for homeless people in the area of flat affect and lack of emotion. Fifty percent of our respondents demonstrated at least a minimal level of difficulty on the scale and, using moderate and above as the cutting point, 22 percent can be considered as having problems that would create difficulties in negotiating community living.

Table MHS13

Retardation - Lack of Emotion
Clinical Severity Distribution

CATEGORY	Number	%
Extreme	51	5.2
Severe	38	3.9
Moderate	124	12.7
Mild	100	10.2
Minimal	175	17.9
None	491	50.2
Total	979	100.0

Agitation-Excitement. This scale is concerned with "overt signs of agitation or excitement" and is designed to measure such things as respondent inability to sit still, pacing, handwringing, accelerated speech, hyperactivity and the like (Spitzer, et al., 1970, p. 44). The scale is composed of seven items, all of which are equally weighted, and its potential score is from 0 (no true items) to 7 (all items true). An agitated person would be one who, for example, talks rapidly, fidgets or moves about restlessly.

Table MHS14 presents the raw score distribution of the information we obtained from respondents. The range of scores is from 0 to 7; the mean is .64 (median = 0, mode = 0), and the standard deviation is 1.15. This distribution is also highly positively skewed.

Table MHS14

Agitation - Excitement Frequency Distribution

```
Scores                                          #
   7 .  *                                       2
     .
     .  *                                       4
     .
     .  *                                       6
     .
     .  **                                     24
   3 .
     .  ****                                   48
     .
     .  *******                                85
     .
     .  ***********                           154
     .
   0 .  *******************************************656
        ----+----+----+----+----+----+----+----+---
        * MAY REPRESENT UP TO 14 COUNTS
```

Table MHS15 displays the recategorization of this scale into clinical severity categories. Almost 83 percent of our respondents fell into the none, minimal and mild categories. The remaining 17 percent can be considered as impaired because their scores correspond to the presence of characteristics or behaviors that likely create problems in daily living or in interacting with other people.

Table MHS15

Agitation-Excitement Clinical Severity Distribution

CATEGORY	Number	%
Extreme	36	3.7
Severe	48	4.9
Moderate	85	8.7
None, Minimal or Mild	810	82.7
Total	979	100.0

Grandiosity. This six-item scale is concerned with "inflated appraisal of worth, contacts, power or knowledge; boasting; sensational plans; delusions of power, status, knowledge or contact; and hallucinations with a grandiose annotation" (Spitzer, et al., 1970, p. 45). The scale is designed as a measure of reality testing disturbance and, with clinical weights assigned to various items, has a potential score range of 0 (no items true) to 12 (every item true). A higher score means higher pathology.

Table MHS16 presents the raw scores on the Grandiosity scale. The range of scores is from 0 to 11; the mean is .37 (median = 0, mode = 0), and the standard deviation is 1.29. The scale is the most positively skewed of all of the distributions.

Table MHS16

Grandiosity Frequency Distribution

```
Scores                                                  #
  11 .  *                                               2
     .
     .  *                                               2
     .
     .  *                                               3
     .
     .  *                                               2
     .
     .  *                                               3
     .
     .  *                                               8
   5 .
     .  *                                               4
     .
     .  *                                               9
     .
     .  *                                              14
     .
     .  *                                              14
     .
     .  *****                                          80
     .
   0 .  ***********************************************838
        ----+----+----+----+----+----+----+----+----+---
        * MAY REPRESENT UP TO 18 COUNTS
```

Table MHS17 presents the Grandiosity scores recategorized according to clinical severity. The most notable characteristic of this distribution is that almost 94 percent of our respondents scored in the none, minimal, or mild categories, and that less than one percent were considered to be extreme.

Table MHS17

Grandiosity Clinical Severity Distribution

CATEGORY	Number	%
Extreme	9	0.9
Severe	24	2.5
Moderate	28	2.9
None, Minimal or Mild	918	93.8
Total	979	100.1

Suspicion-Persecutions-Hallucinations. This 18-item scale assesses "distrustfulness; feelings of having been mistreated, taken advantage of, tricked or pushed around; ideas of reference; various paranoid delusions; (and) auditory hallucinations which mock, threaten or command" (Spitzer, et al., 1970, p. 45). The scale also is a measure in the domain of reality testing disturbance and, with the clinical weights applied to certain variables, has a potential range of 0 (no true items) to 44 (every item true). Behaviors or characteristics that indicate a respondent has problems in this area might include, for example, exaggerated complaints about peers or authority, hearing voices, perceptions of persecution, or actions based on hallucinations or delusions. Again, a higher score indicates a greater degree of disturbance or problems.

Table MHS18 presents the raw score distribution obtained from our respondents. The range of scores is from 0 to 41; the mean is 3.01 (median = 0, mode = 0) and the standard deviation is 5.80. This distribution is also highly positively skewed.

Table MHS18

Suspicion - Persecutions - Hallucinations
Frequency Distribution

```
Scores                                                    #
  41 .  *                                                 1
     .  *                                                 1
  37 .
     .  *                                                 1
  33 .  *                                                 1
     .  *                                                 7
  29 .  *                                                 3
     .  *                                                 2
  25 .  *                                                 5
     .  *                                                 3
  21 .  *                                                 6
     .  *                                                 9
  17 .  *                                                13
     .  *                                                 7
  13 .  **                                               17
     .  **                                               22
   9 .  **                                               25
     .  ****                                             47
   5 .  ******                                           76
     .  **********                                      120
   0 .  *******************************************613
        ----+----+----+----+----+----+----+----+---
        * MAY REPRESENT UP TO 13 COUNTS
```

In Table MHS19, scores are recategorized according to clinical severity. It is again the case that a high proportion of respondents, almost 80 percent, have scores that correspond to the none, minimal and mild severity categories. The remaining 20 percent are likely to have behavioral configurations that result in some impairment or reduced capacity to either interact meaningfully with other people or carry out normal roles and responsibilities.

Table MHS19

Suspicion - Persecutions - Hallucinations
Clinical Severity Distribution

CATEGORY	Number	%
Extreme	24	2.5
Severe	52	5.3
Moderate	120	12.3
Mild	111	11.3
Minimal	59	6.0
None	613	62.6
Total	979	100.0

By way of summary, the following are some observations that can be made about the scores obtained on the ten symptom dimensions discussed above. First, it is of considerable interest to note that the shape of almost all of these distributions matches the type of distribution one would expect to find in the measurement of psychiatric symptomatology. Psychiatric symptoms exist, especially in general populations, as rare phenomena, that is, proportionally fewer people have psychiatric impairment compared to the general population as a whole (Maxwell, 1972). When measuring this symptomatology, distributions have a reversed J, or positively skewed, shape with most respondents having little or no difficulty and with an increasingly smaller number of people presenting more serious symptom presence. All of our scales, except Depression-Anxiety, exhibit this shape with some, notably Suicide-Self-mutilation, being extremely positively skewed.

The distributions we obtained stand in contrast to the picture presented by the popular literature about homelessness and by some researchers who have reported on the prevalence of mental illness among homeless people. For example, Arce and Vergare (1984) state "it is evident that in most universes of homeless people, between 25 percent and 50 percent have serious and chronic forms of mental illness" (p. 88). Ellen Bassuk, reporting in the Scientific American (1984, p. 42) found a 90 percent incidence of "diagnosable mental illness" in a shelter in Boston and has generalized that finding to most homeless persons. These figures imply levels of psychiatric symptomatology among homeless people that, when measured, would be distributed much differently than our distributions. While no precise interpretive standard exists, it would be very difficult to infer from our data that the symptoms we measured indicate the presence of the levels of extreme psychopathology implied by the above writers.

Second, it is important to examine the percentages of respondents who had symptom scores that placed them in clinical severity categories of moderate and above, which we think correspond to the potential service needs of homeless people. Table MHS20 lists a rank ordering of the symptom scales by the percentages of people who scored moderate and above.

Table MHS20

Symptom Scales Ranked by the Percentage of Respondents Scoring Moderate and Above*

SCALE	%
Speech Disorganization	29.6
Inappropriate Affect, Appearance or Behavior	24.4
Retardation-Lack of Emotion	21.8
Suspicion-Persecutions-Hallucinations	19.9
Depression-Anxiety	18.4
Agitation-Excitement	17.3
Disorientation-Memory Impairment	15.5
Grandiosity	6.2
Suicide - Self-mutilation	3.5

* Interview Belligerence not included because cut-off scores were not available from the authors of the PSS.

These percentages indicate that some service needs are apparent for homeless people, that the percentages of people needing those services is variable by symptom area and that, in general, these percentages tend to be lower then the popular literature on homelessness would suggest, although higher than distribution of percentages among the general population.

Defining and Assessing Multiple Symptom Severity

This section is concerned with our attempt to construct two indices of severity based on the premise that psychiatric impairment is often a function of multiple symptoms rather than one. Our approach to the problem was straightforward. Essentially, we defined two severity indices--psychiatric and behavioral--based on the domain relatedness of our symptom scales according to Spitzer, et al. (1970, p. 44). For example, the Psychiatric Severity Index is composed of the Depression-Anxiety, Suicide-Self-mutilation, Grandiosity and Suspicion-Persecutions-Hallucinations symptom scales. These scales relate to subjective distress and reality testing, respectively. The Behavioral Disturbance Severity Index, on the other hand, is composed of the Agitation-Excitement, Disorientation-Memory Impairment, Inappropriate Affect, Appearance or Behavior, Speech Disorganization and Retardation-Lack of Emotion symptom scales.

Further justification for combining these symptom scales into simple indices came from two sources. First, Spitzer, et al. (1980) reported that three of the scales included in the Psychiatric Severity Index, Suspicion-Persecutions-Hallucinations, Depression-Anxiety and Suicide-Self-mutilation, discriminated between a group of outpatients and a community sample (point biserial correlations were .45, .53 and .34, respectively). These correlations indicate that respondents who were mental health clients tended to have higher scores on these symptom scales than those respondents who were not clients.

A second justification for combining symptom scales comes from a finding in our study that replicates the Spitzer, et al. data reported above. Our data were organized in a slightly different way, however, because we used hospitalized-for-mental-health-problems vs. not-hospitalized as our discrimination groups. Table MHS21 presents the point biserial correlations of the hospitalized variable and PSS symptom scales.

Table MHS21

Correlations Between Psychiatric Hospitalization Experience and PSS Scale Scores

	PSS Scale	Point Biserial Correlation
Subjective Distress	Depression-Anxiety	.28
	Suicide-Self-mutilation	.24
Behavioral Disturbance	Speech Disorganization	.14
	Inappropriate Affect, Appearance or Behavior	.03
	Agitation-Excitement	.03
	Interview Belligerence-Negativism	.04
	Disorientation-Memory Impairment	.06
	Retardation-Lack of Emotion	.06
Reality Testing Disturbance	Grandiosity	.19
	Suspicion-Persecutions-Hallucinations	.30

An examination of these correlations indicates that three of the subscales that Spitzer, et al. found to be related to the use of mental health services also tend to be related to hospital experience in the homeless group. Depression-Anxiety, Suicide-Self-mutilation and Suspicion-Persecutions-Hallucinations all have a modest relationship with hospitalization as indicated by the respective correlations of .28, .24 and .30. Further, Grandiosity also tends to be related, although the correlation coefficient of .19 is somewhat smaller in magnitude than the others. What these correlations say is that homeless people who reported having had one or more hospitalizations for mental health problems also tend to have higher scores on the Depression-Anxiety, Suicide-Self-mutilation, Grandiosity and Suspicion-Persecutions-Hallucinations symptom scales. People with no reported hospitalizations, on the other hand, tend to have lower scores on the these symptom scales.

Both the Psychiatric Severity and Behavioral Disturbance Severity Indices were put together using a simple count method. Basically, the indices reflect the number of symptom scales upon which a respondent's score is moderate and above. Each symptom is treated as equally weighted so that a respondent who scores a one on, for example, the Psychiatric Severity Index could obtain that score because of the presence of any of the four symptom scales. A score of two could reflect any combination of two symptom scales located at the moderate or above level, and so on.

While it is recognized that these indices are a crude measure of severity, they do begin to capture the multiplicity of symptom configuration inherent in most disorders. Our assumption is that severity can be defined as increasing as the number of symptoms a person manifests increases. It is also our assumption that broad levels of service needs can be associated with levels of severity and that the percentages associated with each level can provide rough measures of multiple symptom prevalence within the homeless group.

Table MHS22 presents the Psychiatric Severity Index distribution. To restate, the index is a simple count of the number of symptoms a respondent manifested in the moderate and above range as defined by the Spitzer cut-off scores. It can be seen that almost 70 percent of our respondents scored a zero, a score which corresponds to minimal or no symptomatology in the psychiatric severity area. Almost 18 percent had at least one score of moderate and above, another ten percent had two scores; approximately three percent had three scores and, finally, less than one percent had all four symptoms.

Table MHS22

Psychiatric Severity Index Distribution

# SYMPTOMS	Number	%
0	678	69.3
1	171	17.5
2	93	9.5
3	32	3.3
4	5	0.5
Total	979	100.1

It is again important to point out what these figures imply about psychiatric symptomatology within the homeless group. The figures we are reporting are not consistent with data one would expect to obtain if the respondent group were highly dysfunctional. We observed that about 30.8 percent of our respondents demonstrated the presence of symptomatology that might require the need for a mental health service. Within that 30.8 percent, the percentage of more severe psychiatric impairment decreased to the point that less than five percent might be candidates for highly structured, protective settings.

Table MHS23 presents the Behavioral Disturbance Severity Index distribution. It, too, is a simple count of the number of symptoms a respondent manifested in the moderate and above range. This distribution suggests that behavioral disturbance problems tend to be more prevalent within the homeless group than psychiatric problems. Forty-six percent of our respondent group demonstrated from none to mild symptomatology in this area. Another 37 percent reported only one or two symptoms and the remainder, approximately 17 percent, had three or more symptoms at the moderate and above level. While these data are more difficult to relate to potential mental health service needs, it is the case that homeless people seem to manifest behavioral disturbance more than psychiatric impairment. It is also the case, however, that the behavioral disturbance data also conform to the "relatively rare" distribution expectations discussed above.

Table MHS23

Behavioral Disturbance Severity Index Distribution

# SYMPTOMS	Number	%
0	453	46.3
1	226	23.1
2	140	14.3
3	96	9.8
4	50	5.1
5	14	1.4
Total	979	100.0

As a final point, it is of interest to examine the relationship between the Psychiatric Severity Index and the Behavioral Disturbance Index. This is particularly important because it permits the more precise definition of severity based on the presence of symptomatology from both domains. Also, the overlap between the two scales will be essential to examine as a means to identify more specific psychiatric disorders based on subjective distress, reality testing and the behavior of the respondent.

Table MHS24 presents the cross-tabulation of psychiatric severity and behavioral severity. It can be seen that some overlap between the two indices exists as indicated by the presence of percentage values in most of the cells. It is the case, however, that this overlap is fairly small, with 20.5 percent of our respondents demonstrating the presence of both psychiatric problems and behavioral disturbance problems.

Table MHS24

Psychiatric Severity Cross-tabulated with
Behavioral Disturbance Severity
(Percentaged, N=979)

Number of Psychiatric Symptoms Moderate or Above	Number of Behavioral Disturbance Symptoms Moderate or Above						
	0	1	2	3	4	5	Total
0	36.2	15.6	8.0	6.0	2.9	0.5	69.2
1	6.6	4.5	3.4	1.8	0.8	0.3	17.5
2	2.9	2.5	1.7	1.1	0.9	0.4	9.5
3	0.6	0.5	1.0	0.8	0.3	0.1	3.3
4	0.0	0.0	0.2	0.0	0.2	0.1	0.5
Total	46.3	23.1	14.3	9.7	5.1	1.4	100.0

Three distinct groups can be defined from these data. The first group is composed of those persons who have zero scores on both scales, that is, those who can be considered as relatively symptom free. About 36 percent of our respondents can be put in this category. The second group is composed of those respondents who have at least one behavioral disturbance problem but no psychiatric symptom problems. These are people who likely behave in ways that might be considered odd or deviant, but who do not demonstrate the presence of problems that could require psychiatric services. About 33 percent of our respondents can be thus classified.

The third group is composed of the remaining respondents who demonstrated the presence of at least one psychiatric symptom. Included in this group are the people who have only a psychiatric symptom problem (10.1%), and the above mentioned group who had both a psychiatric symptom problem and a behavioral disturbance problem (20.5%). We have defined this group under the assumption that the presence of one or more problem psychiatric symptoms is the paramount concern in establishing the mental health status of a respondent and that the co-presence of one or more behavioral disturbance problems with a psychiatric problem aids in helping define the psychiatric problem or disorder more precisely. As noted above, 30.8 percent of our respondents can be classified into this group.

Comparing Homeless Persons to Other Groups

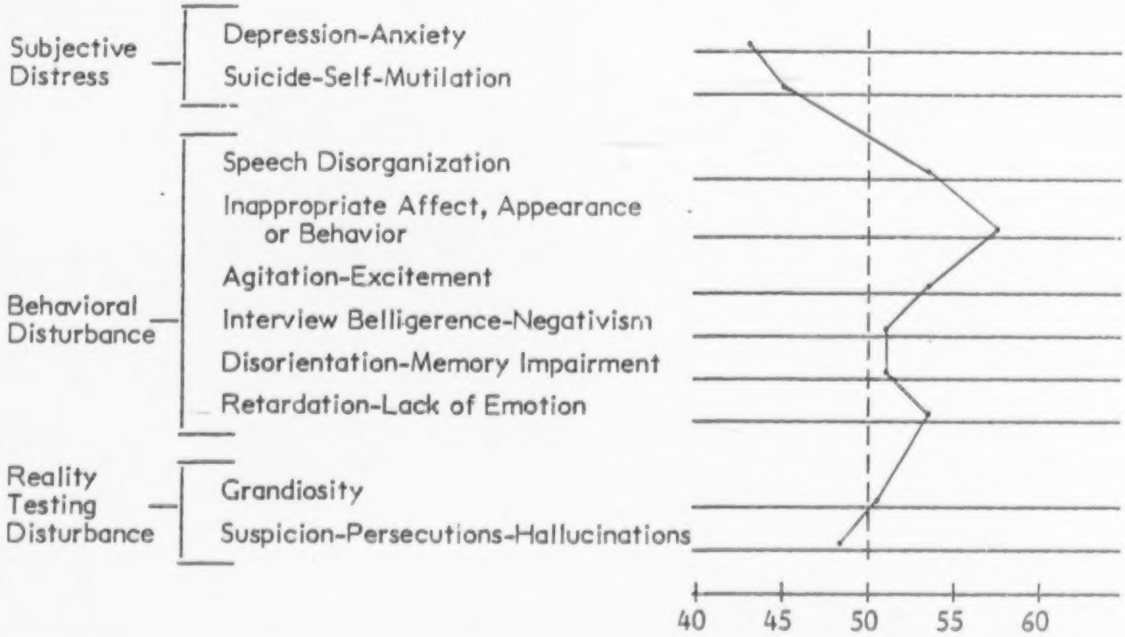
Understanding data obtained about psychiatric symptomatology of one group can be enhanced by a comparison of this information to other reference groups. We were able to obtain statistical information about two groups which we felt could serve to make some useful comparative statements relative to our homeless respondents.

The first group to which we compared our respondents was composed of 770 newly-admitted psychiatric inpatients. This group is actually one that Spitzer used to examine PSS scale characteristics and, also, is one about which Spitzer makes available scale means and standard deviations. The characteristics of our study group are reported to be similar to newly-admitted inpatients, in general, although it is important to know that information about the inpatients was collected in the early-1970's. Because of this time differential and, therefore, the likely existence of different criteria for admission, we are reporting this comparison with the caution that the relationships between the two groups might be different if more recent inpatients were used. Unfortunately, PSS data about recent inpatients were not available.

Figure MHS-F1 presents the comparison between our homeless respondent group and Spitzer's early-1970's newly-admitted inpatients. This comparison was done by a standardization procedure through which the scores of the homeless respondent group were transformed to T-scores using the means and standard deviations of the inpatient group. The expected value of the mean of standard scores is fifty, and the standard deviation is ten. As a guide to interpretation, if the homeless respondents were identical to the inpatients, the mean of each scale (located by the dot and connected by the solid lines) would be located at the value of fifty. To the extent that homeless respondents are better, on the average, within a symptom area, the mean will be located below fifty. Conversely, if homeless respondents are worse within a symptom area, the mean will be located above fifty.

Figure MHS-F1.

Comparison of Homeless Respondents to Spitzer's 770 Newly-Admitted Inpatients



An examination of Figure MHS-F1 points out the differences and similarities between our homeless respondents and Spitzer's early-1970's inpatients. On the subjective distress measures, Depression-Anxiety and Suicide-Self-mutilation, homeless respondents' scores are lower, indicating less pathology, than the 1970's inpatients. They are also lower on the Suspicion-Persecutions-Hallucinations scale, although to a lesser extent. On the other scales, homeless respondents appear to score higher than the 1970's inpatients. This is especially evident on the scales that measure affect, appearance and behavior, where the scores are considerably higher than those of Spitzer's inpatients.

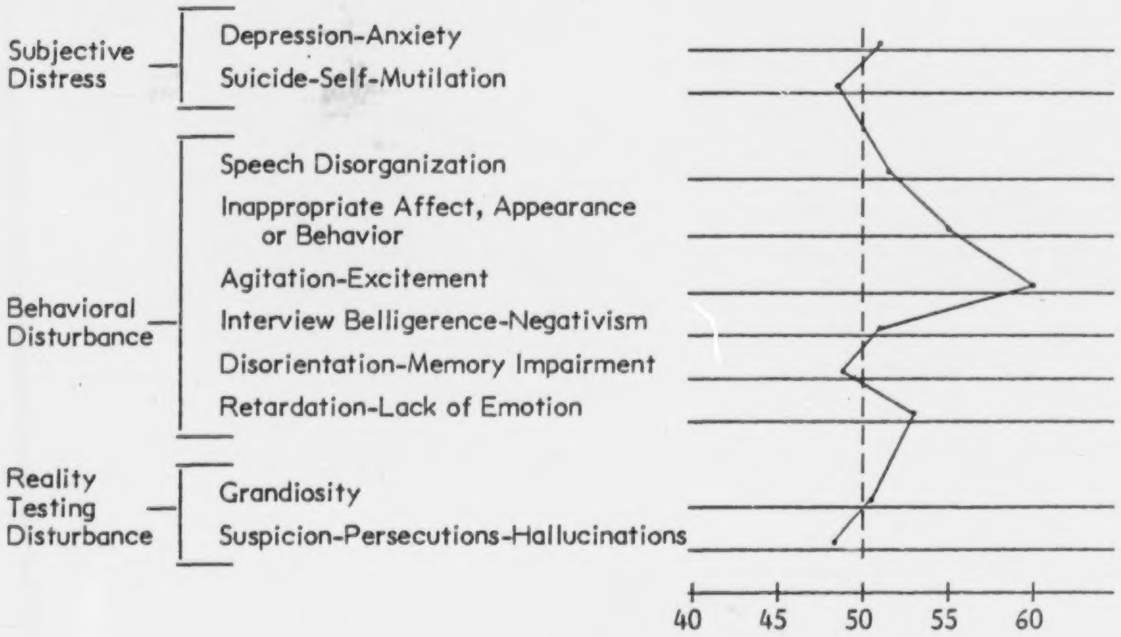
An interesting, but tentative, explanation can be given for this pattern of similarities and differences. While our homeless respondents tend to have higher means, behaviorally speaking, than Spitzer's early 1970's inpatients, they perform substantially better on the symptom scales that are demonstrated to be more adequate measures of psychiatric dysfunction. The types of behavior exhibited by homeless people and their appearance is sometimes odd or, possibly, dysfunctional, but it is not necessarily related to a mental health service need. It could be this phenomenon, in fact, that accounts for the larger estimates of "chronically mentally ill homeless" that have been reported in other sources.

The second group to which we compared homeless people was composed of 229 transitional services clients who had been living in the general community for one year. These clients were respondents in a research project that sought to examine the types of factors that facilitated success in community adjustment after discharge from a state hospital. This research was conducted in Ohio in the late 1970's by two of the university-based staff on this project. It should be restated that this group is composed of people who had been engaged in the mental health system for psychiatric services and who were successfully maintained in the community after psychiatric hospitalization. It is, from that standpoint, a more dysfunctional group than one drawn from the general population.

Figure MHS-F2 presents the comparison between our homeless respondents and the transitional services group. The scores are again T-scores, using the transitional services data for the standardization. The general pattern of scores indicates similarity between the groups on all the dimensions except those related to behavior or appearance--Inappropriate Affect, Appearance or Behavior, Agitation-Excitement and Retardation-Lack of Emotion. It is apparent here that our homeless respondents look more dysfunctional than transitional services clients from a behavioral standpoint, and look similar from a psychiatric standpoint.

Figure MHS-F2.

Comparison of Homeless Respondents to 229 Ohio Transitional Services Clients



The data from these comparisons are interesting given the composition of the groups. Homeless respondents scored better than inpatients on those scales that measure psychiatric distress suggesting that, in general, homeless people are not in need of hospitalization. They tend to be much more psychiatrically similar to clients who have been living successfully in the community. On the behavioral scales, however, our homeless respondents are consistently more dysfunctional than either group. We think that what these data may indicate is the interaction between stresses of living a homeless lifestyle and the presence of behaviors or characteristics that are often perceived to be related to psychiatric dysfunction. The Behavioral Disturbance scales clearly measure areas where problems are exacerbated by the exigencies of homelessness. For members of the comparison groups, resources existed to take care of their basic survival needs. For our homeless respondents, however, basic survival demands were immediate and sometimes pressing. It is our opinion that some of the differences on the behavioral disturbance scales can be accounted for by that fact.

Mental Health Status, Psychiatric Hospitalization and Community Mental Health Center Use

One of the principal reasons this study was conducted was the need to understand how well the mental health system responds to the mental health needs of homeless people. This issue is particularly important because of the ongoing assertion by advocates for homeless people that mental health policies, whether they be those relating to "deinstitutionalization" or those concerned with restrictive hospital admission standards, are a primary cause of homelessness in this country. In this section, we present results that address the crucial overlap between the mental health status of homeless people and the extent to which the mental health system addresses these needs.

Before presenting these findings, however, it is important to clarify how we chose to define mental health system use in this analysis. Two questions were included in the questionnaire to ascertain mental health system contact by homeless people. The first question asked if the respondent had ever been in a hospital for emotional or mental health problems. The second question asked if the respondent had used community mental health center services within the past month. Based on the yes-no response categories to these questions, we created four categories of system use: (1) respondent was hospitalized and had used a community mental health center; (2) respondent was hospitalized and did not have community mental health center contact; (3) respondent was not hospitalized and had used a community mental health center, and (4) respondent was not hospitalized and did not have community mental health center contact.

In the analysis, the above categories of system use were related to our summary measure of mental health status, the Psychiatric Severity Index. While the index is presented in its entirety to represent the degree of problem presence within each group, to a large extent the focus of this analysis was on two groups defined by the index: those who demonstrated no psychiatric symptomatology and those who presented one or more symptom areas that could require the need for mental health services.

Table MHS25 presents the relationship between the mental health status of our homeless respondents and their system use. The table is structured as a three-way cross-tabulation where hospitalization and community mental health center use are down the columns, and psychiatric severity is across the rows. Our analysis of these data has two parts: first, we look at the overall system use by each of the four groups and, second, we examine the extent to which mental health needs are being addressed through this use.

Focusing first on system involvement, it can be seen that 82 (8.6% of the total respondent group) of our respondents indicated that they had been hospitalized for a psychiatric problem and also reported having used a community mental health center. We also know from a more detailed examination that 62 (75.6%) of the respondents in this category are people who were in state psychiatric facilities, leaving 24.4 percent who had another type of hospitalization and also had community mental health center use. The number of people who reported a hospitalization and no community mental health center use was 208, approximately 22 percent of our respondent group. Again, a more detailed examination indicated that 118 (56.7%) of the respondents in this category reported having been in a state facility.

The bulk of our respondents, almost 70 percent, reported that they had never been hospitalized for a psychiatric problem. Of this group, a small number of people, 36 (4% of the total respondent group), indicated that they had been in contact with a community mental health center within the past month. The remaining 632 respondents (66% of the total respondent group) indicated that they had neither been in a psychiatric hospital nor had they used a community mental health center service.

Table MHS25

Psychiatric Severity of Homeless Respondents by
Community Mental Health Center Use and
Psychiatric Hospitalization Experience

		HOSPITALIZATION				
		YES		NO		
		CMHC USE		CMHC USE		
	# Symptoms	Yes (%)	No (%)	Yes (%)	No (%)	Total (%)
Psychiatric Severity Index Score	0	35 (42.7)	101 (48.6)	20 (55.6)	506 (80.1)	662 (69.1)
	1	22 (26.8)	50 (24.0)	8 (22.2)	86 (13.6)	166 (17.3)
	2	12 (14.6)	42 (20.2)	4 (11.1)	35 (5.5)	93 (9.7)
	3	9 (11.0)	15 (7.2)	4 (11.1)	4 (0.6)	32 (3.3)
	4	4 (4.9)	0 (0.0)	0 (0.0)	1 (0.2)	5 (0.5)
		82 (100)	208 (100)	36 (100)	632 (100)	958 (99.9)

A few summary highlights can be stated about the mental health system involvement of homeless people based on these data. First, as noted previously in the report, about 30 percent of our respondents indicated they had been in any psychiatric facility. Within that group, nine percent of our respondents had used community mental health center services. Further, a high percentage (72%) of those reporting both a hospitalization and community mental health center use were people who had been in state facilities, suggesting a predictably closer link between state hospitalization and community mental health center use. However, a high percentage of state hospitalizations (57%) were also found for those hospitalized but reporting no community mental health center contact, indicating that the relationship between state hospitalization and community mental health center use is imperfect. Finally, only a small percentage of respondents (4%) indicated that they had been in contact with a community mental health center but had never been hospitalized.

Assessing the extent to which this system involvement meets the mental health needs of homeless people is the focus of the second part of our analysis of these data. Two assumptions have been made in this analysis: first, that a score of one or above on the Psychiatric Severity Index indicates mental health services need and, second, that a "yes" response to the community mental health center use question indicates that mental health needs are potentially being addressed.

Given these assumptions, the following observations can be made about our data. First it should be restated and emphasized that 662 (69.1%) of our respondents have a zero score on the Psychiatric Severity Index, a score which corresponds to no or minimal symptom severity. The breakdown of this group across the categories of system involvement is important because it indicates that having been in a hospital or having used a community mental health center does not necessarily correspond to continued problem severity or need. For example, the frequency of zero Psychiatric Severity Index scores in the first three columns in Table MHS25 (which indicates some form of system involvement) add to 156, about 16 percent of the total number of respondents. We think these are people who have been adequately served by the system or who have simply improved in their psychiatric functioning. It is also important to highlight the fact that 506 of our total number of respondents (53%) reported having had no psychiatric hospitalization, no community mental health center contact and did not demonstrate the presence of problem psychiatric symptomatology.

A second observation about these data is that some of the mental health needs of homeless people are currently being addressed by the system. With the previously stated assumptions in mind, we estimate that 63 (7%) of our total number of respondents are likely having their needs addressed. More accurately stated, of the 296 respondents who demonstrated need, those 63 actually represent 21.3 percent who are likely to be having their needs addressed.

Finally, we know from these data that homeless people have mental health needs that are not addressed by the mental health system. It is important to identify two groups who appear to have such unmet needs. First, a group of people can be defined who report having been hospitalized, having had no community mental health center use and who demonstrate the presence of one or more problem symptoms. A total of 107 (11% of the total) respondents can be thus classified. The composition of this group is made up of people who have been released from a psychiatric facility and did not make contact with a community mental health center or people who were released at one point in time and had a recurrence of psychiatric problems.

The second group who have unmet needs can be defined as having no hospitalization, no community mental health center use and the presence of problem symptomatology. A total of 126 (13% of the total respondents) have this configuration of characteristics. This group of people is composed of those homeless persons who have psychiatric problems but that have never made contact with the system.

Mental Health Status of Urban and Non-Urban Homeless People

Another stated objective of this study was to identify differences between homeless people found in urban and non-urban areas, not only on the dimensions discussed extensively in a previous section of the report, but relative to their mental health status as well. Tables MHS26 and MHS28 present an overview of mental health status as measured by the Psychiatric Severity Index and Behavioral Severity Index, respectively, by the type of county in which the interview occurred.

An examination of Table MHS26 indicates very little difference between the two groups in the psychiatric severity scores of respondents. For example, if you compare the percentage of respondents reporting no problem symptoms, the urban group has a slightly higher percent of people (70.1% vs. 65.6%) than the non-urban group. The percentage difference (4.5%) is fairly small, however. For respondents who were observed to have had at least one psychiatric symptom, the differences by number of symptoms are very similar. The five respondents who were most dysfunctional (number of symptoms = 4) were interviewed in an urban setting.

Table MHS26

Psychiatric Severity by Type of County

# SYMPTOMS	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
0	554	70.1	124	65.6	678	69.3
1	131	16.6	40	21.2	171	17.5
2	75	9.5	18	9.5	93	9.5
3	25	3.2	7	3.7	32	3.3
4	5	0.6	0	0.0	5	0.5
Total	790	100.0	189	100.0	979	100.1

In order to make a more precise assessment of the psychiatric functioning of respondents, we examined each of the PSS scales used in creating the Psychiatric Severity Index. To do this assessment, we simply calculated the percentage of respondents who scored at the moderate or above level of severity on each scale by the type of county in which the interview occurred. The data are displayed in Table MHS27. Non-urban respondents tend to have slightly higher percentages on the Suicide-Self-mutilation and Suspicion-Persecutions-Hallucinations scales and tend to be slightly lower on the Grandiosity scale. On the Depression-Anxiety scale, however, the difference between the two groups tends to be somewhat higher (6.0%), suggesting that non-urban respondents may be more depressed or anxious than urban respondents.

Table MHS27

Psychiatric Symptom Scales by Percentage of Respondents Scoring Moderate and Above by Type of County

SCALE	URBAN	NON-URBAN
Depression-Anxiety	17.3	23.3
Suicide-Self-mutilation	3.6	3.7
Suspicion-Persecutions-Hallucinations	19.8	21.2
Grandiosity	7.0	3.2

The Behavioral Disturbance Index presented in Table MHS28, however, suggests that real differences between non-urban and urban respondents exist from a behavioral perspective. Looking again at the no-symptom category, the differences between the groups is high (18%), with non-urban respondents showing fewer problems than urban respondents. This is, of course, opposite to the psychiatric severity finding noted above, where rural respondents tended to show slightly more psychiatric problems than did their urban counterparts. It is also the case that problem magnitude is more severe for urban respondents. The frequencies that correspond to three or more problem areas indicate that a higher proportion of urban respondents (19.1%) have three or more behavioral disturbance problems, compared to 4.7 percent of non-urban respondents.

Table MHS28

Behavioral Disturbance Severity by Type of County

# SYMPTOMS	URBAN		NON-URBAN		TOTAL	
	Number	%	Number	%	Number	%
0	338	42.8	115	60.8	453	46.3
1	182	23.0	44	23.3	226	23.1
2	119	15.1	21	11.1	140	14.3
3	88	11.1	8	4.2	96	9.8
4	49	6.2	1	0.5	50	5.1
5	14	1.8	0	0.0	14	1.4
Total	790	100.0	189	99.9	979	100.0

A more detailed exploration of the behavioral disturbance differences was done by examining non-urban/urban score distributions of each of the PSS scales that were used to create the Behavioral Severity Index. Table MHS29 presents that information. The differences between these percentages indicate that, for all scales, non-urban respondents had less problems than those from urban areas. Respondents were most alike on the Agitation-Excitement scale, where the difference was less than four percent. On the other hand, considerable difference between the groups can be seen on the Speech Disorganization scale, where the difference is nearly 20 percentage points.

Table MHS29

Behavioral Disturbance Symptom Scales by Percentage of Respondents Scoring Moderate and Above by Type of County

SCALE	URBAN	NON-URBAN
Inappropriate Affect, Appearance or Behavior	27.3	12.7
Agitation-Excitement	18.0	14.3
Retardation-Lack of Emotion	24.6	10.1
Speech Disorganization	33.4	13.8
Disorientation-Memory Impairment	17.0	9.5

These data on the mental health status of urban and non-urban respondents can be summarized as follows. Urban and non-urban homeless people tend to be very similar in terms of psychiatric symptomatology. The groups were essentially equivalent on the Psychiatric Severity Index and only Depression-Anxiety tended to be different on the PSS scales used to construct the index. From the behavioral point of view, however, a different picture emerges. Homeless people in urban areas tend to have more behavioral disturbances than non-urban homeless people. Urban respondents were consistently worse on the specific PSS scales used to construct the Behavioral Severity Index, and in some cases the difference between the two groups was substantial.

Mental Health Status of Types of Homeless People

This section essentially extends the discussion of our attempt to identify similarities and differences between the types of homeless people we interviewed. In the analysis presented here, we examine the mental health status of our respondents, principally as measured by the Psychiatric Severity Index and the Behavioral Disturbance Index, by the types of homelessness categories defined earlier in the report. To restate, those categories were: 1) Street People--individuals who were interviewed on the street and who indicated that they did not use shelters; 2) Shelter People--respondents who used shelters, and 3) Resource People--those who stayed in cheap hotels/motels or with family or friends and did not use shelters.

Table MHS30 displays the psychiatric severity breakdown by the three types of homeless respondents. The information in this table indicates that minimal differences exist between these groups. The percentage of respondents who had no problem symptoms is nearly the same for each group, the difference separating the three groups being less than five percent.

Table MHS30

Psychiatric Severity by Type of Homelessness

# SYMPTOMS	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
0	94	67.6	390	69.4	175	72.3	659	69.9
1	23	16.5	100	17.8	40	16.5	163	17.3
2	16	11.5	53	9.4	20	8.3	89	9.4
3	6	4.3	14	2.5	7	2.9	27	2.9
4	0	0.0	5	0.9	0	0.0	5	0.5
Total	139	99.9	562	100.0	242	100.0	943	100.0

The magnitude of problem severity is also similar in each group. At each level of severity, response percentages are equivalent or very nearly so. The only possible notable characteristic of these data is that the five most disturbed respondents were interviewed in a shelter setting.

The data in Table MHS31 present a more detailed view of the psychiatric symptoms of the groups. The data presented are percentages of respondents who scored at the moderate or above level on the specific PSS scales used in the Psychiatric Severity Index. The groups are quite similar on the Suicide-Self-mutilation, Suspicion-Persecutions-Hallucinations and Grandiosity scales. On the Depression-Anxiety scale, however, the differences between Street People and both the Shelter and Resource groups are notable, six percent and eight percent, respectively. This finding would be consistent with the notion that street life is more uncertain and stressful and would be likely to elicit both depressive and anxious responses from "street" type respondents.

Table MHS31

Percentage of Respondents Scoring Moderate and Above on Psychiatric Symptom Scales by Type of Homelessness

SCALE	STREET	SHELTER	RESOURCE
Depression-Anxiety	23.7	17.6	15.7
Suicide-Self-mutilation	2.9	3.7	2.5
Suspicion-Persecutions-Hallucinations	21.6	19.9	17.4
Grandiosity	4.3	6.4	6.2

The Behavioral Disturbance Severity Index broken down by type of homelessness is presented in Table MHS32. These data suggest that differences between the groups do exist in this domain, with Street People appearing much more behaviorally dysfunctional than either the Shelter group or the Resource group. In fact, 71.1 percent of the Street respondents had at least one problem symptom, compared to 51.0 percent of the Shelter group, and 50.9 percent of the Resource group. The difference of approximately 20 percent for each comparison indicates that Street People have substantially more behavioral problems than other respondents.

Table MHS32

Behavioral Disturbance Severity by Type of Homelessness

# SYMPTOMS	STREET		SHELTER		RESOURCE		TOTAL	
	Number	%	Number	%	Number	%	Number	%
0	40	28.8	275	48.9	119	49.2	434	46.0
1	38	27.3	131	23.3	50	20.7	219	23.2
2	26	18.7	80	14.2	28	11.6	134	14.2
3	21	15.1	44	7.8	28	11.6	93	9.9
4	12	8.6	28	5.0	10	4.1	50	5.3
5	2	1.4	4	0.7	7	2.9	13	1.4
Total	139	99.9	562	99.9	242	100.1	943	100.0

Table MHS33 presents a more detailed examination of group differences in the behavioral disturbance area. Overall, the Street respondents have proportionally higher numbers on the five scales, which is consistent with the Behavioral Severity Index finding discussed above. Comparing the Shelter group to the Resource group, it appears that Shelter People are, to a small extent, less dysfunctional than the Resource People since they have lower percentages on four of the five scales. The exception is Retardation-Lack of Emotion, where the Shelter group percentages are slightly higher.

Table MHS33

Percentage of Respondents Scoring Moderate and Above
on Behavioral Disturbance Scales by Type of Homelessness

SCALE	STREET	SHELTER	RESOURCE
Inappropriate Affect, Appearance or Behavior	36.0	22.4	24.0
Agitation-Excitement	26.6	13.4	21.5
Retardation-Lack of Emotion	28.1	21.0	19.4
Speech Disorganization	42.5	27.9	28.1
Disorientation-Memory Impairment	18.7	14.1	16.5

The principal scales upon which Street People differ from other respondents are Inapproriate Affect, Appearance or Behavior and Speech Disorganization. On the Inappropriate Affect, Appearance or Behavior scale, the percentage difference between Street and Shelter respondents is 13.6 percent, and the Street and Resource difference is 12.0 percent. The Speech Disorganization scale has the highest percentage of respondents for all groups, with the difference between Street and Shelter People being 14.6 percent, and the Street and Resource difference being 14.4 percent.

In summary, there are meaningful mental health status differences between the types of homeless people we interviewed. The most obvious of these differences exists between Street People and the Shelter and Resource groups. Street People tend to be slightly more depressed and anxious and are clearly more behaviorally dysfunctional than the other two groups. As noted above, this finding is consistent with the idea that life on the street is stressful and evokes or serves to maintain both psychiatric and behavioral problems.

Correlates to the Mental Health Status of Homeless People

Bachrach (1984c, p. 912) has suggested that an area of needed research about the condition of homelessness should focus on how demographic profiles differ between those homeless people who are mentally ill and those who are not. What follows is a discussion of our attempts to address this gap in understanding through the development of a statistical model that relates a series of characteristics and conditions of homeless people to a measure of their mental health status. Our attempt here was to represent the multidimensionality of the relationship between the homeless condition and mental health.

The approach employed to do this analysis is called hierarchical regression using sets (Cohen & Cohen, 1975, p. 127). Hierarchical regression is simply an extension of multiple linear regression, the difference being that in the hierarchical approach, a series of models are identified with a new variable added to each subsequent model. The focus of the analysis is on the increase in the explanatory capacity of the model with the new variable added. This logic can be extended to sets of variables where the interest is in how much improvement in explanation is obtained with the addition of a variable set.

For this analysis, five variable sets were identified. The first of these is called the Demographics set and is composed of respondents' sex, age, marital status, ethnicity and military service experience. It is important to note here that some of our measures are categorical and thus required recoding in order to be used in the analysis. For two-

-response category variables, a simple dummy code was used. For multiple response variables, an effects coding scheme was employed (see Cohen & Cohen, 1975, pp. 188-195).

The second set identified is called Homelessness and includes type of homelessness, degree of transience and time spent homeless. The third set is called Resources and is measured by respondents having worked in the past month, had income, having friends to count on and having relatives to count on. The fourth set is called Problems, and it includes hospitalization, jail or prison, medical problems, drugs, and having sought help for drinking. Finally, a Subjective Rating of Life Experience set was identified and included the general well-being questions.

The dependent variable used in the analysis is the PSS scale measuring Depression-Anxiety. The use of this scale as the proxy for mental health status was based on two considerations. First, a number of epidemiologists have agreed that the symptoms of depression and anxiety are often present in many forms of mental illness and have a high prevalence in general populations (American Psychiatric Association, 1978; Roth, et al., 1972; Ware, et al., 1979; Warheit & Bell, 1979). The second consideration was more practical and was concerned with the distributional properties of our symptom scales. The Depression-Anxiety scale was the least skewed of our measures and was, therefore, likely to give a more accurate measure of relationship than a more highly skewed PSS scale.

Table MHS34 presents the results of the analysis. The variable sets are listed in the order in which they were included in model building. For example, Demographics and Depression-Anxiety were examined first. Then Homelessness was added at the second step and its contribution to explanation was observed. Resources, Problems and Subjective Rating were entered at the third, fourth and fifth steps, respectively. In the table, two statistical values are noted. R^2 is the measure of the explanatory power of the variables in the model at that step. The Increment value is the measure of how much explanatory power is represented by the addition of the set, over and above information entered prior to that step. The following interpretation should clarify the method.

For the variable set Demographics, the R^2 value of .042 indicates that slightly more than four percent of the variance of the Depression-Anxiety scale can be explained by demographic information. Since the maximum R^2 value obtainable is 100 percent and the minimum is zero percent, this R^2 indicates that a knowledge of these demographic variables does not substantially assist in our understanding of depresion and anxiety in homeless people. While it is the case that the R^2 is low, two demographic variables appeared to be related to the Depression-Anxiety scale. Specifically, it was found that divorced or separated, or white respondents tended to be more depressed or anxious than other respondents.

When the variable set Homelessness is added to the model, R^2 increases to .07. The increment to R^2 attributed to this set is .028, which means that the ability to explain Depression-Anxiety is only slightly increased (by 3%) by the information conveyed in the set. Interestingly, while the increment is small, all three measures were systematically related to the Depression-Anxiety scale. Street People who were more transient in their moving around and who reported having been on the street for a longer time tend to have higher scores on the scale.

Table MHS34

Hierarchical Set Analysis of Depression-Anxiety
in Homeless People

VARIABLE SET	DEPRESSION-ANXIETY
Demographics	
R^2	.042
Sex	—
Age	—
Marital status	divorced, separated
Ethnicity	white
Military service	—
Homelessness	
R^2	.070
Increment	.028
Type of homelessness	street
Degree of transience	higher
Time spent homeless	longer
Resources	
R^2	.100
Increment	.030
Worked	no
Had income	yes
Had relatives	no
Had friends	no
Problems	
R^2	.196
Increment	.096
Hospitalized for psychiatric problems	yes
Been in jail or prison	—
Medical problems	yes
Taken drugs	—
Sought help for drinking	yes
Subjective Rating of Life Experience	
R^2	.394
Increment	.198
Rating of well-being	negative
Rating of life satisfaction	negative

At the next step, Resources, added a further three percent to the model. Again, although modest overall, each variable in the set was related to Depression-Anxiety. People who had not worked, who reported having had some income and who did not have relatives or friends upon which they could count, tended to have higher Depression-Anxiety scores than other respondents. Except for the income variable, the relationship of these variables to Depression-Anxiety seems consistent with what might be expected, that is, that a lack of resources contributes to increased depression or anxiety in a person. The inverse relationships between income and Depression-Anxiety is more difficult to explain. One interpretation is that minimal financial resources accentuate the financial plight of homeless people. Paradoxically, they may have enough money to know it isn't enough to live on.

With the addition of the Problems set, a substantial jump in R^2 occurs. The increment value of .096 indicates there is almost a ten percent increase in the variance explained in depression and anxiety through the addition of this set to the model. Three variables account for the increase. It appears that respondents who had been hospitalized for psychiatric problems, had medical problems and who had sought help for drinking were more likely to be depressed or anxious. Neither jail or prison experience nor drug usage were shown to be related to this symptom area.

Finally, when the Subjective Rating of Life Experience set was added, R^2 rose dramatically to .394, an increase of nearly 20 percentage points in the variance explained in Depression-Anxiety. Both measures in this set were related to the symptom area, and it was the case that a negative rating of well-being and of life satisfaction correspond to increased scores on the Depression-Anxiety scale.

Taken as a whole, an impresive 39.4 percent of the variance in Depression-Anxiety can be accounted for by the full model. The variables that relate to depression and anxiety and the direction of their relationships are consistent with the types of relationships one would see in the general population. A point to be made from this analysis is that there do not appear to be relationships expressed between the characteristics of homeless people and their mental health that are remarkably different or abnormal from people who have places to live. The only difference is the modest contribution of the Homelessness set to Depression-Anxiety, where it appears that mental health status is negatively affected by virtue of being homeless, certainly an understandable relationship. Beyond that, it is no surprise to find that a lack of financial and social resources, prior psychiatric problems, medical or drinking problems and a negative rating of well-being and life experience all contribute to more depression and anxiety in homeless people.

HOSPITAL SURVEY RESULTS

Direct admissions to adult state psychiatric hospitals were monitored for six months to determine the number and proportion of individuals who were homeless at the time of their admission. Overall, 6.7 percent of all admissions to these hospitals were defined by hospital social workers to be homeless at the time of their admission (Table H1). Almost all hospitals admitted some homeless individuals during that period, except Longview State Hospital and Western Reserve Psychiatric Habilitation Center, which have a limited receiving function and very few direct admissions, most of the patients being transferred from other institutions. The proportion of homeless admissions to other hospitals ranged from a low of 0.8 percent at Woodside Receiving Hospital, to a high of 11.3 percent at Central Ohio Psychiatric Hospital. At least part of this variation could be explained by differences in the socioeconomic characteristics of the populations served by these hospitals. Most of the institutions with higher proportions of homeless patients admitted cover large metropolitan areas where the proportion of homeless individuals in the general population is expected to be higher (such as Central Ohio Psychiatric Hospitals, Rollman Psychiatric Hospital, Dayton Mental Health Center, etc.). Portsmouth Receiving Hospital, on the other hand, serves a rural area, but with a very low socioeconomic status population. At Woodside Receiving Hospital, however, serving a population both urban and poor, the proportion of homeless patients admitted was unexpectedly low (0.8%).

Table H1

Patients Who Were Homeless at Admission to State Psychiatric Hospitals
March 15 - September 14, 1984

INSTITUTION	Number Admissions	Number Homeless	Percent Homeless
Cleveland Psychiatric Institute	1,690	93	5.5
Fallsview Psychiatric Hospital	969	77	8.0
Portsmouth Receiving Hospital	348	34	9.8
Rollman Psychiatric Institute	810	78	9.6
Woodside Receiving Hospital	651	5	0.8
Athens Mental Health Center	219	15	6.9
Central Ohio Psychiatric Hospital	803	91	11.3
Cambridge Mental Health Center	362	12	3.3
Dayton Mental Health Center	519	44	8.5
Longview State Hospital	41	----	0.0
Massillon State Hospital	180	20	11.1
Toledo Mental Health Center	746	23	3.1
Western Reserve Psychiatric Habilitation Center	42	----	0.0
TOTAL	7,380	492	6.7

In addition to determining whether patients were homeless at the time of admission, social workers categorized these individuals into the four levels of homelessness delineated in the initial research design. Most of the homeless patients fell into two of the categories. Level 1 (limited or no shelter) accounted for 37 percent of the homeless admissions, while 36.6 percent fell into Level 4 (others/with family or friends). Level 2 (shelter or mission) accounted for 17.5 percent of the homeless admissions, and only 8.9 percent of those individuals who were homeless at the time of admission were in Level 3 (cheap motels and hotels). From the brief unstructured descriptions of the residential status of these patients provided by many of the social workers as supporting data, two distinct patterns of homelessness for hospitalized individuals seemed to emerge:

-- 109 patients (22.2%) had a history of eviction or loss of residence concurrent with the worsening of their psychiatric status, resulting in aggressive or otherwise intolerable behavior (beating up relatives or roommates, being destructive to the apartment, etc.); these patients were living more often with relatives or friends for relatively short periods of time (Level 4) at the time of admission.

-- 96 patients (19.5%) were described as migrants, moving from place to place and in many instances from state to state, apparently incapable of settling down; they were generally less severely disabled than those in the previous group and used to living more frequently on the streets (Level 1), in public shelters (Level 2) or in cheap motels for short periods of time (Level 3).

Another category of admissions deserves attention despite the fact that patients in this category did not qualify as homeless according to the study criteria (and were not considered as such). The 90 patients in this group were initially misreported as homeless because they were considered by the hospital social workers as potentially homeless at discharge. Most of these subjects (78 persons, 86.7% of the group) were not able to return to their previous residence either because they had been evicted/removed from their homes the day they were admitted to the hospital, or because the persons who owned or were in charge of their residences would not accept them back. The remaining twelve patients in this group (13.3%) actually had a residence they could return to, but were living alone and were incapable of caring for themselves because of their deteriorated functional status. The total number of individuals who would be homeless if discharged is undoubtedly significantly greater, since this group of patients was detected by chance, as an artifact of the study.

COMMUNITY SURVEY RESULTS

Among the patients discharged from state psychiatric hospitals to the sample areas during FY 1982-1983, 5,448 (60.8%) have been identified in the active files of the community mental health agencies in urban areas, and 597 (70.9%) in those of the community agencies in non-urban areas (see Tables C1 and C2). A relatively small but significant proportion of the patients discharged were identified as having become homeless by the community mental health agencies at some point after discharge from the hospital.

Table C1

Individuals Identified as Homeless Following Discharge from State Psychiatric Hospitals in FY 1982-1983

Urban Areas

COUNTY	Discharged from Hospitals	ON ACTIVE CASELOAD		HOMELESS	
		No.	% of Discharged	No.	% of Discharged
Cuyahoga	4,253	2,682	63.1	118	2.8
Franklin	1,673	1,077	64.4	103	6.1
Hamilton	1,934	1,092	56.5	73	3.8
Lucas	1,099	599	54.5	36	3.3
Total Urban	8,959	5,448	60.8	330	3.7

Table C2

Individuals Identified as Homeless Following Discharge from State Psychiatric Hospitals in FY 1982-1983

Non-Urban Areas

NON-URBAN AREA	Discharged from Hospitals	ON ACTIVE CASELOAD		HOMELESS	
		No.	% of Discharged	No.	% of Discharged
Northwest	131	80	61.1	4	3.1
Northeast	126	106	84.1	13	10.3
Central	74	56	75.7	2	2.7
Southwest	147	81	55.1	5	3.4
Southeast	364	274	75.3	9	2.5
Total Non-Urban	842	597	70.9	33	3.9

There were 330 homeless individuals (3.7% of those discharged) identified in urban areas, and 33 (3.9% of those discharged) in non-urban areas. Although the proportion of patients discharegd who were found homeless was very similar (3.7% and 3.9% respectively), these individuals were actually more than twice as numerous compared to the population in urban areas (8.9 per 100,000 population) than in non-urban areas (4.1 per 100,000 population). The latter finding is consistent with the rates of patients discharged during the study period, which were 242.7 per 100,000 population in urban areas and 105.0 in non-urban areas.

Within urban and non-urban areas, there was a great variation in the proportion of individuals identified as homeless after discharge, across geographical areas. In urban areas, the proportion ranged form 2.8 percent in Cuyahoga County to 6.1 percent in Franklin County, while in non-urban areas it ranged from 2.5 percent in the Southeast Region to 10.3 percent in the Northeast Region. Part of this variation is attributable to actual differences in the proportion of individuals discharged who became homeless. Some of the urban community mental health agencies serving populations in low socio-economic areas have identified significant numbers of homeless subjects among the patients discharged, such as Columbus Area Community Mental Health Center in Franklin County (58 persons), Westside Community Mental Health Center and Community Guidance Center in Cuyahoga County (42 and 39 persons, respectively), Mental Health Services Northwest in Hamilton County (18 persons), Comprehensive Alcoholism Service Systems in Lucas County (23 persons), etc. Surprisingly, however, other agencies serving similar populations did not identify any homeless subjects among the patients discharged, such as the Northeast Community Mental Health Center in Cuyahoga County and the Zepf Community Mental Health Center in Lucas County. For non-urban areas, the greatest number of homeless individuals among the patients discharged was identified by the Guidance Center of Ashland in Northeast Region (13 persons), an agency very knowledgeable about the residential status of its clients.

Apart from real differences in the proportion of patients who became homeless following discharge in various areas, significant biases may have resulted from the following circumstances:

a) Differences in proportions of patients who never contacted community mental health agencies after discharge or contacted agencies in areas different from their original residential areas.

b) Differences between community mental health agencies in their knowledge about the residential status of their clients. We estimate this to be the most significant source of bias responsible for unexplained differences in proportion of homeless individuals identified in various areas.

c) Some community mental health agencies in urban areas have failed to provide us with this information so far. This bias is probably responsible for some of the unexplained differences between the proportions of homeless individuals in various areas, as well as for the difference between the proportion of patients discharged who were found on the active caseload of community agencies in urban areas and those in non-urban areas.

In addition to determining whether individuals in the discharge sample were homeless, community mental health agency personnel were asked to categorize those individuals into the four levels of homelessness delineated in our initial research design. As can be seen in Table C3, those patients who became homeless in urban areas were almost equally likely to be living on the streets (Level 1--32.7%), in shelters (Level 2--29.1%) or for brief periods with family and friends or in other unique situations (Level 4--32.7%). In contrast, as Table C4 shows, nearly half (48.5%) of the patients who became homeless in non-urban areas were in Level 4.

Table C3

Individuals Identified as Homeless Following Discharge from State Psychiatric Hospitals, by Level of Homelessness

Urban Areas

COUNTY	Total Homeless Individuals	LEVEL OF HOMELESSNESS 1	2	3	4
Cuyahoga	118	32	35	11	40
Franklin	103	36	32	2	33
Hamilton	73	26	18	3	26
Lucas	36	14	11	2	9
Total	330	108	96	18	103
Percent by Level of Homelessness		32.7	29.1	5.5	32.7
Percent of Discharged		1.2	1.1	0.2	1.2

Table C4

Individuals Identified as Homeless Following Discharge from State Psychiatric Hospitals, by Level of Homelessness

Non-Urban Areas

NON-URBAN AREA	Total Homeless Individuals	LEVEL OF HOMELESSNESS 1	2	3	4
Northwest	4	1	2	1	—
Northeast	13	3	1	2	7
Central	2	—	—	—	2
Southwest	5	1	1	—	3
Southeast	9	1	1	3	4
Total	33	6	5	6	16
Percent by Level of Homelessness		18.2	15.2	18.2	48.4
Percent of discharged		0.7	0.6	0.7	1.9

SUMMARY OF RESULTS

Perhaps the most important findings of the research are that homelessness is a multi-faceted issue, that homeless people have a variety of problems, and that there are subtypes within the homeless population which need to be distinguished in order for the phenomenon of homelessness to be more fully understood.

The Homeless Person Survey

After hearing at length from nearly 1000 homeless people across Ohio, economic factors emerged as a primary theme. For half the group, economic reasons were the major cause of their homelessness, and nearly one quarter (21.3%) cited family conflict as the reason they were without a home.

Many of the stereotypes of homeless people in the popular literature were not supported by study findings. Our group was less mobile--most had stayed in two or fewer places in the past month--and less transient than might have been expected: 63.5 percent had either been born in the counties in which they were interviewed or had lived there longer than a year. Most (87.3%) had worked at some point in their lives, and a quarter had worked for pay in the past month. Nearly half of those who had been employed in the past but were not working now said they had looked for a job but had been unable to find one. Almost two-thirds (63.4%) had some source of income in the past month, primarily from welfare, earnings or Social Security. The picture that emerges is one of a largely indigenous population made up of people who are not totally without funds but whose income is not sufficient to pay for permanent housing.

In addition to their lack of housing, jobs, and resources, homeless people have a variety of other problems. Only a third (36.0%) said they had relatives they could count on, and 41 percent said they had friends they could count on. This seems to indicate that not all homeless people are isolated from social support as has been portrayed in the popular literature. However, comparative data from a needs assessment in five rural Southern Ohio counties provides a more realistic contrast. In that study, 92.4 percent of the general population said they had relatives they could count on and 94.9 percent said they had friends. A third of our sample (30.7%) had physical health problems, and almost an equal percentage (30.8%) had psychiatric problems. Thirty percent had had a psychiatric hospitalization. Well over half (64.2%) said they had been drinking some or a lot in the past month, and 26.6 percent indicated they had sought help for a drinking problem at some point in their lives.

Differences Between Urban and Non-Urban Homeless People

Differences were found between urban and non-urban (those from mixed and rural counties) homeless groups on some of the study variables but not on others. While nearly half of both groups cited economic reasons as the primary cause of their homelessness, family problems was a greater cause in non-urban areas (28.6%) than in urban areas (19.5%). Respondents in the urban counties (42.3%) were far more likely to report that they were born in the county in which the interview took place than were respondents in non-urban counties (28.6%). Of those individuals who were not native to the county, non-urban homeless people (49.6%) were more likely to have migrated from elsewhere within Ohio. By contrast, non-native urban homeless people (65.2%) were more likely to have come from another state. Urban homeless people (22.1%) were more likely than non-urban people (8.1%) to have migrated seeking work, while non-urban people (43.7%) were more like than their urban counterparts (19.7%) to have moved to be near friends or relatives.

A high percentage of both urban and non-urban homeless people had held a job at some point in their lives, but non-urban respondents (32.8%) were more likely than urban respondents (22.2%) to have worked for pay in the past month. For those not now working, 61.8 percent of non-urban people and 43.9 percent of urban people said they had looked for work but were unable to find a job. Non-urban respondents (79.4%) were more likely than urban respondents (59.8%) to report having had income the past month, but welfare and earnings were the major sources for both groups.

There were substantial differences evidenced in social support networks. Non-urban homeless people were ten percent more likely to say they have relatives they can count on and twenty percent more likely to say they have friends they can count on for help. Nearly one quarter of urban homeless people said they had no relatives, in contrast to 9.5 percent of non-urban homeless people. Rates of physical health problems, psychiatric problems and psychiatric hospitalization did not differ substantially, but urban respondents were somewhat more likely to report problems with alcohol use.

Types of Homelessness

Three distinct sub-types of homeless people emerged out of the data analysis: Street People, who do not use shelters, Shelter People, and Resource People--individuals who do not use shelters and are able to stay in cheap hotels or with family and friends for short periods of time. Resource People were found to have been homeless for a shorter period of time (median of 35 days) than Street People (median of 60 days) or Shelter People (median of 90 days), but there were no substantial differences across groups in their reasons for homelessness. Street People and Resource People were slightly more likely to be native residents of their counties, but the differences were not large.

Over ninety percent of Shelter People had had a job at some point in their life, compared to 81.8 percent of Resource People and 77.7 percent of Street People. While two-thirds of the overall homeless group said they had income the past month, there were differences in percentages among Street People (49.6%), Shelter People (62.6%) and Resource People (73.6%). The major sources for all groups were welfare and earnings.

In the area of social support, there were only small differences among the three types of homeless people in percentages reporting that they had family or friends they could count on. Street People had the lowest percentages, followed by Shelter People and Resource People. Small differences were also recorded in percentages reporting health problems (21.9% of Resource People, 33.3% of Shelter People, and 36.0% of Street People), and psychiatric hospitalization (20.7% of Resource People, 27.3% of Street People and 32.7% of Shelter People), but there were no differences in levels of psychiatric problems across the three types. More Street People reported alcohol use, but Shelter People (31.8%) and Street People (25.9%) indicated that they had sought help for a drinking problem more than Resource People (12.4%).

Homelessness and Mental Health

The relationship between homelessness and mental health is one about which many stereotypic perceptions exist. The more recent literature about homelessness is replete with references to the notion that most, if not all, homeless people are mentally disabled and are either former mental patients or are in need of mental hospitalization. Data from our study do not support these views about homeless people.

As indicated previously, 29.9 percent of our respondent group said that they had experienced at least one psychiatric hospitalization in any type of facility. Eighteen percent of the overall sample indicated that they had been in a state mental hospital, with a median number of hospitalizations of two. Most of the state-hospitalized respondents were last released in 1983 or 1984 (45.5%), but nearly one-fourth (23.9%) were last released in 1978 or earlier. Upon their last release from a state hospital, 60 percent of the respondents said that community living arrangements had been made for them, and most (88.0%) went to the place arranged.

The conclusion that most homeless people are "deinstitutionalized" simply does not emerge from these data. The numbers given above do not correspond to a widespread and systematic contribution to homelessness by Ohio's state hospitals and community mental health system. Only six percent of our total respondent group reported having been last hospitalized during the period 1960-1980 when the state hospital system census had a dramatic decline. Since 1980, there has been only a minimal decline in state hospital populations with an increased emphasis on community-based care. Compared to the pre-1980 time period, since 1980 only a slightly higher percentage of our total respondent group (10.7%) were found to have been last released from a state hospital. Also, in the survey of community mental health agencies, it was determined that approximately four percent of the patients discharged from state hospitals during FY 1982-1983 were found to be homeless.

In terms of current mental health status, the study measured ten symptom dimensions through use of the Psychiatric Status Schedule. The scales employed to assess these symptoms were more meaningfully combined into two summary indices, a Psychiatric Severity Index and a Behavioral Disturbance Severity Index. Of the overall respondent group, 30.8 percent exhibited the presence of at least one symptom in the Psychiatric Severity Index at the level of moderate and above. In our opinion, based on the types and extent of problems measured by these scales, this group of respondents would likely require some form of mental health service.

On the Behavioral Disturbance Severity Index, 53.7 percent of the respondents exhibited at least one symptom at the level of moderate and above. Interpreting these data as a measure of mental health needs was a more difficult task because the areas measured were complexly intertwined with the stresses and demands of a homeless lifestyle. While it is true, for example, that a dirty or disheveled appearance, inappropriate behavior, flattened affect, and the like can be considered as signs of a mental disorder, they can also be seen as the results of difficult circumstances in which homeless people find themselves.

It is again the case that study findings stand in contrast to current views about homeless people. The idea that most homeless people are mentally ill and in need of mental hospitalization is not supported by the data. In fact, study findings can be compared to a recent general population mental health assessment (Myers, et al., 1984) which gives a 20 percent prevalence rate of mental disorder. Using this as a base, it can be said that the prevalence of mental disorders among homeless people is somewhat higher than that found in the general population.

The subjective rating of mental health and life satisfaction by homeless respondents was important to assess because of the perception of some people that homeless people tend to be that way by choice and must be, therefore, generally satisfied. On the rating of life satisfaction, 33.5 percent of the respondents said they were very or somewhat satisfied with their life. In response to the question about the rating of nerves, spirits, outlook or mental health, 40.4 percent of the responses indicated their response to be excellent or good.

These figures, standing alone, show that not every homeless respondent views his or her condition or life in negative terms. However, when compared to general rural population figures, a dramatic change in interpretation occurs. For example, on the life satisfaction question, 86.5 percent of the respondents in a general population survey in rural Ohio indicated they were either very or somewhat satisfied with their life. This is a 53 percent increase over the homeless group of respondents. On the mental health rating, 85.4 percent of the general population respondents fell in the categories of excellent and good, a percentage difference of 45 points compared to homeless respondents. These data suggest clearly that while some homeless persons do not tend to rate their experience in negative terms, they do tend to be much less satisfied than at least the rural general population with their life and less favorable in the rating of their own mental health.

DISCUSSION AND SERVICE IMPLICATIONS

Understanding what the extensive data we collected say about homelessness in Ohio has been and will continue to be a difficult task. The complexity of the problems experienced by homeless people must be unraveled and understood by public policy makers and service providers if effective and enduring solutions are to be found. At this point, we have only scratched the surface about how our study can inform planning.

While admittedly preliminary, this section of the report addresses what we think are key facts and issues that must be considered as responsive services and programs are conceived. First, we present an effort to develop a general picture of the needs of Ohio's homeless people through a summary problem inventory. Next, we discuss some service decision and delivery implications indicated by our study findings and by perspectives about where change should occur. Finally, we present a proposed planning framework that we think will result in responsive services to homeless people.

A Problem Inventory

In an initial effort to distill meaning from our data, we have organized major findings into a problem inventory (see Table D1). This inventory communicates very important messages about homelessness in Ohio, or at least about the nearly one thousand homeless people we interviewed. As a needs statement, it presents the proportion of our homeless respondents who were experiencing, at the time of the interview, problems in each area. Further, the percentages in each area provide a means to rank or order problems in terms of their magnitude and, therefore, how they should be emphasized in policy and program development.

Table D1

Problem Inventory of Homeless People in Ohio
(N=979)

AREA	% Reporting Problems
HOUSING	100.0
EMPLOYMENT	
- No work for pay during last month	75.3
- Looked, could not find work	29.5
- Disabled, could not work	13.0
- Do not want to work	3.0
- Not job ready	5.0
SOCIAL SUPPORT	
- No relatives, or cannot count on relatives	64.2
- No friends, or cannot count on friends	58.1
- Neither friends nor relatives, or cannot count on friends or relatives	43.1
DRUG/ALCOHOL USE	
- Any type of drug or medication use	32.2
- Trouble with drugs or medications	4.8
- Reported alcohol use	64.2
- Reported having sought alcohol treatment	26.6
- Reported both alcohol and drug or medication use	39.2
PHYSICAL HEALTH	
- Any type of physical health problem	30.7
MENTAL HEALTH	
- Psychiatric symptom presence requiring service	30.8

The first and most pressing need of the people we interviewed is for a permanent, adequate home. While it is a statement of the obvious, that is, to be included in the study interviewees had to be without a home, the implications for policy makers and service deliverers is clear--in Ohio there are people who lack the assurity of one of the most basic human needs, that of adequate shelter. "Housing needs" is used in the broadest sense. We think that homeless people require different types of housing, ranging from simply affordable dwellings to more structured, sheltered settings operated by various human services agencies. It was evident from our study that homeless people are resourceful and either improvise temporary quarters, use public shelters, or stay with family and friends. However, all of the situations we encountered in the course of our research were temporary and offered only a stop-gap answer to an immediate problem.

Second, the percentage of homeless persons who had not recently worked was large. We used the response to the question as to whether or not a respondent had worked for pay during the past month to rank this question, and it can be seen that just over 75 percent reported that they had not worked. Many reasons for not working were voiced and, when considered together, they suggest that employment and job services for homeless people are desperately needed. Our data suggest that these services should be broadly defined to include those related to the individual such as training, job-seeking skills and job maintenance skills, as well as those related to potential employers of homeless people such as job identification and development. It is not the case that we think all homeless people should have jobs. For those disabled, it may not be a viable expectation. We do believe, however, that access to gainful employment should be assured.

Next was the fact that a large number of our respondents had minimal social support in terms of having any family and friends, or having friends or relatives upon whom they could rely. We used responses to the question about relatives to rank this area because usually, families provide more direct assistance and support to other family members than friends. It is also the case that 58.1 percent of our respondents did not have friends, or friends they could count on, and that 43.1 percent had neither friends nor relatives, or friends and relatives upon whom they could count. These data indicate that homeless people experience isolation and a lack of meaningful social contact to a large degree. Given recent findings that social support is often the key factor in the ability of marginal members of society to enjoy a meaningful and productive life, it seems necessary to consider how the concept can be translated into responsive services for homeless people.

A number of our respondents reported alcohol use. The percentage used to rank this question was obtained from the question about having used alcohol some, a lot, or none of the time. Sixty-four percent of our respondents indicated that they used alcohol some or a lot of the time. Alcohol use and homelessness are terms that tend to be thought of together and our data certainly support the notion that many homeless people consume alcoholic beverages. The extent to which it is a problem in their lives is less clear, since only 26.6 percent reported having sought treatment for alcohol problems. However, it seems evident that some level of alcohol services are needed for this group.

Drug use follows alcohol use in our listing with about 32 percent of our respondents reporting having used drugs. Data in this area are confounded by the fact that our question included prescription and over-the-counter drugs as well as illicit drugs. Whether prescribed or not, however, about one-third of the homeless group interviewed had available and used drugs, a fact that we think should be of interest to service providers. While only 4.8 percent of our group indicated trouble with drug use, we did not pursue this issue further and therefore the percentage is likely an under-estimate.

Mental health and physical health problems are virtually tied for the next position in the ranking, with slightly over 30 percent of our respondents indicating or exhibiting problems in each area. Physical health problems covered a range of disorders and diseases. The assessment of psychiatric symptoms among homeless people was completed through acceptable psychiatric epidemiologic methods and the study indicated that some homeless people presented symptoms that would require a mental health service. This finding stands in stark contrast to the opinion of many that all or very nearly all homeless people are mentally ill.

Service Design and Delivery Implications

In the literature on homelessness, a number of efforts have been made to identify program and policy areas within which services to homeless people should be identified. For example, New York Governor Mario Cuomo, in his report to the National Governor's Association Task Force on Homelessness (1983), indicated that the following seven national policy areas should be reviewed and reconsidered, if necessary:

> "1. adequacy of the number and quality of emergency shelters for single men and women, for families, for victims of domestic violence, and for youth;
>
> 2. adequacy of existing regulations and enforcement procedures to ensure minimal levels of decency in such facilities;
>
> 3. adequacy of discharge planning and aftercare--including appropriate residential placement--in psychiatric facilities;
>
> 4. adequacy and fairness of shelter and basic living allowances for those on public assistance;
>
> 5. adequacy and fairness of general relief regulations, especially as they affect the single, able-bodied man or woman;
>
> 6. adequacy and fairness of current housing policies, especially as they affect low-income individuals;
>
> 7. adequacy and effectiveness of monitoring and review procedures to ensure that government does not lose touch with the people affected by its policies." (p. 74)

More recently, the American Psychiatric Association (1984) listed a series of recommendations for policies and programs that meet the needs of that part of the homeless population which is mentally ill. They begin first with a major recommendation:

> "To address the problems of the homeless mentally ill in America, a comprehensive and integrated system of care for this vulnerable population of the mentally ill, with designated responsibility, with accountability, and with adequate fiscal resources, must be established." (p. 5)

The following are identified as some derivative recommendations:

> "1. Any attempt to address the problems of the homeless mentally ill must begin with provisions for meeting their basic needs: food, shelter, and clothing.

2. An adequate number and sample range of graded, step-wise, supervised community housing settings must be established.
3. Adequate, comprehensive, and accessible psychiatric and rehabilitative services must be available, and must be assertively provided through outreach services when necessary.
4. General medical assessment and care must be available.
5. Crisis services must be available and accessible to both the chronic mentally ill homeless and the chronic mentally ill in general.
6. A system of coordination among funding sources and implementation agencies must be establshed.
7. General social services should be provided." (pp. 5-9)

It is clear from the above that our study findings do not substantially conflict with either of these sets of recommendations. Homelessness in Ohio has been shown to be a multifaceted problem that will require complex solutions and a number of the areas in which solutions must be found have been identified by either Governor Cuomo or the American Psychiatric Association, or both.

Any quarrel we have with the recommendations would relate to how they might be emphasized in planning for services to homeless people. We think our study data indicate how various needs should drive the planning process and how resources should be linked to services. For example, it is our opinion that there is a need to adopt the view that the first and foremost concern expressed by homeless people is the need for a permanent place to stay and for resources sufficient to maintain that place. While all the other problems obviously require solutions, it is the housing and resource problem that must be addressed first in social policy. In fact, we would argue that an accurate assessment of the service needs of homeless people cannot occur until adequate housing and resources are made available to those people. It is very likely that an entirely different picture would emerge, and one that is much less dysfunctional, if people were to start first with basic resources.

A second point to be raised about how recommendations are emphasized in service planning is concerned with basic issues related to problem cause and social change. The various areas identified by Cuomo and the American Psychiatric Association imply certain solutions that need to be fundamental and far-reaching, and others that are temporary. For example, the construction of shelters and services provided within shelters should be seen as a temporary solution, since it in no way addresses essential questions about housing policies that have displaced and will continue to displace vulnerable people. Increased welfare benefits and access to those benefits, while important to homeless people in immediate need, cannot be seen as a replacement for more enduring policy changes that encourage and facilitate access to employment opportunities.

Further, the view of problem cause will affect potential solutions. At the risk of oversimplification, two views emerge from the various recommendations made about how to develop social service policy for homeless people. The first view can be identified as one that considers homelessness a response to social policies and processes that disenfrancise vulnerable people. Within this view, changes in economic, social and health policies in this country are the principal reasons why people are homeless. The alternative view suggests that homelessness is the result of severe personal deficits--

psychological, emotional, social, vocational. Within this perspective, the individual is seen to be the problem and the fact that the person is homeless clearly is an indication of something wrong with him or her.

The implications of these two views for planning policy are profound. The larger view, that policies contribute to homelessness, suggests solutions that are more structural and enduring. The individual focus tends to lead toward remedies that attend to the more immediate needs of homeless people, an obviously important focus, but often one that results in temporary or "bandaid" solutions. The real need is to proceed with policy development and program planning with the understanding that both perspectives must be included, balanced and acted upon. The problem of homelessness is both structural and individual, with the two areas interacting in complex ways that are only beginning to be understood. Neither can be assumed to be the exclusive reason why people are homeless.

A Proposed Planning Framework

In the final part of this report, we would like to advance a planning framework that incorporates what we know about the problems of homelessness in Ohio with the need to derive policies and programs that are both "structural" and "individual" in their focus. The first component of our framework is based on our needs data and policy and program focus. The relationship between these two areas is shown in Table D2. Simply stated, what this first component indicates is: 1) that policy and program areas should be prioritized by prevalence and, thus differentially emphasized in planning deliberations, and 2) that within each area, both "structured" and "individual" policy and programs should be defined. A principal assumption within this component is that "structural" policies and initiatives take precedence in guiding actions and that any "individual"-oriented programs should be considered only if they are consistent with fundamental, long-term solutions.

Table D2

SERVICE AREA	POLICY OR PROGRAM
Housing	Structural Policies: Programs:
Employment	Structural Policies: Programs:
Social Support	Structural Policies: Programs:
Drug/Alcohol	Structural Policies: Programs:
Physical Health	Structural Policies: Programs:
Mental Health	Structural Policies: Programs:

As a second component of the planning framework, it can be seen from this list of needs that services to homeless people will need to come from a variety of sources. In Ohio, a number of agencies, both public and charitable, have been identified as having the capacity to contribute to services for homeless people. It is essential to understand, however, that service responsibilities cannot be neatly compartmentalized within the above potential service areas. Many agencies and organizations provide an array of services, some of which will fall into a number of the various needs categories. For example, the Ohio Department of Mental Health recognizes its responsibility not only to design policies and services that relate to mental health treatment, but also to provide the support and assistance needed for mental health clients to secure and maintain housing. Persons with chronic mental disabilities have few resources; they often have problems negotiating what they need and managing their personal lives. It is therefore necessary for the mental health system to design policy and programs to enhance the capacity of such vulnerable people to maintain a needed living situation.

As a final component of our planning framework, we have identified a range of issues that should guide action in the development of policies and programs for homeless people in Ohio. While these issues are fairly traditional topics in human services planning, the problem posed by homeless people requires careful attention and innovative thinking within each.

1. The multiple needs of homeless people must drive a comprehensive service design.

2. Services to address these multiple needs must be further differentiated by key characteristics of homeless people. There has been an unfortunate tendency to assume that all homeless people are alike. Our study findings highlight the fact that different needs exist for urban and non-urban homeless people and for those who live on the street, in shelters, or who have slightly more resources. We also assume that differences may be detected on the basis of other characteristics (such as sex, age or race) or combinations of characteristics.

3. The link between homeless people and various services, from both an accessibility and availability standpoint, will require innovative thought. We know from our study that homeless people in Ohio can be found in a tremendously wide range of settings and circumstances, and that bridging the gap between those settings and service delivery will likely be difficult.

4. Multiple needs, services, agencies, settings, and a difficult service group make the need for service coordination an absolute necessity. The success of any system designed to provide service to homeless people will hinge on its capacity to coordinate and share information, and maintain an open dialogue.

5. Proactive leadership in the formulation of policy and design of services is also a key component of potential success. In the public arena, such leadership has been lacking because to assert that role has been unfortunately seen as an admission of principal ownership of the problem. With the discovery of the multidimensionality of the problem, leadership can now be seen as facilitative to the development of solutions, not blamed as the cause.

6. The education and training of both policy makers and service providers about homelessness will be necessary. Data from the key informant component of our study indicate an unevenness about what people who ostensibly should know about homelessness do, in fact, know. It also appears that many of these people, some of whom will be key actors in

the planning process, share many stereotypic views about the condition of homelessness and its causes. Further, the traditional training of service providers will likely be insufficient for considering how to implement and provide services.

7. Finally, enduring and effective services to homeless people will only come about through public and private multi-level action. In the public arena, initiatives and actions on the federal, state, and local levels will be required. These activities need to be committed to substantial remediation of the homeless condition and, further, need to be addressed through reasonable levels of funding.

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